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**Health
in the
United
States**

1975

A Chartbook

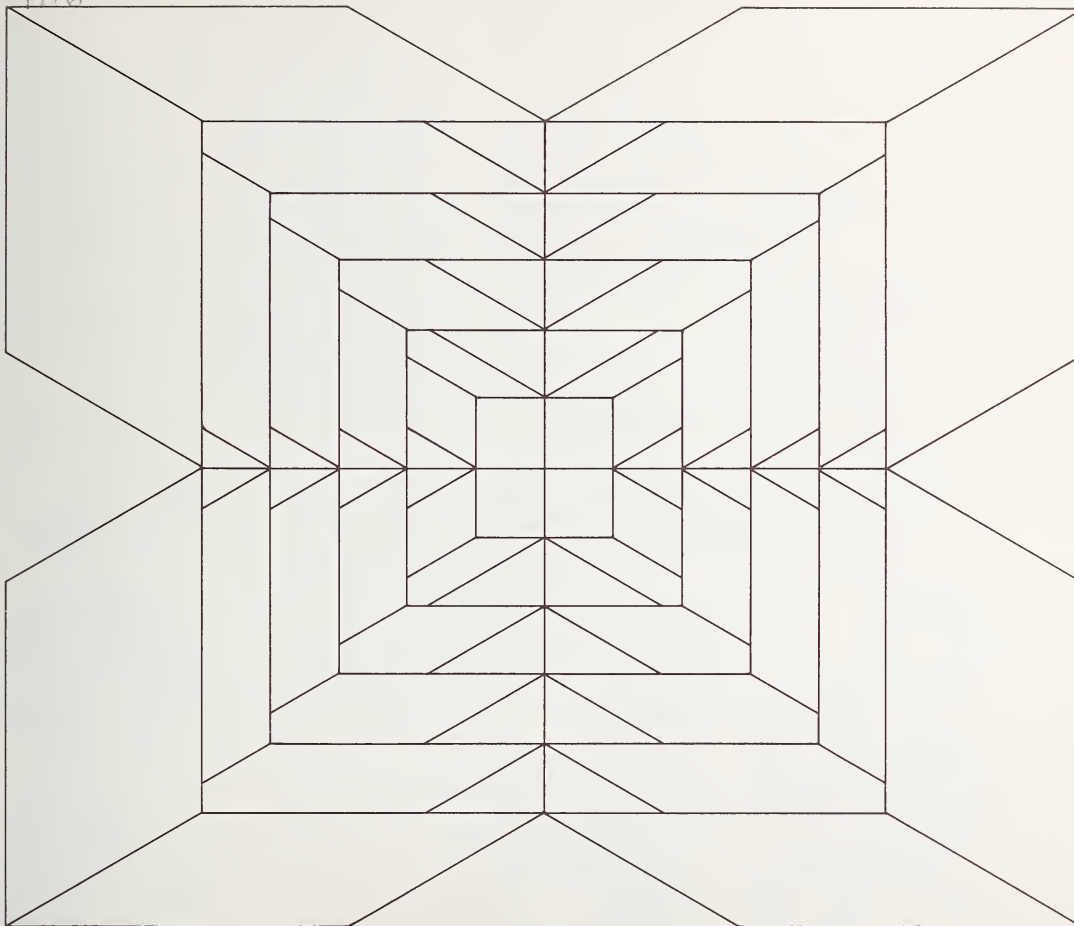
**U.S. DEPARTMENT OF
HEALTH, EDUCATION,
AND WELFARE**
Public Health Service
Administration
National Center for
Health Statistics

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**U.S. DEPARTMENT OF
HEALTH, EDUCATION,
AND WELFARE**

Public Health Service

Health Resources
Administration

National Center for
Health Statistics

Rockville, Md.

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Introduction

Health care patterns in the United States and throughout the world are undergoing rapid change. Advances in medical, diagnostic, and therapeutic techniques have required adaptations in medical practice. The quest for equity of access to medical care for different population groups and for different parts of the country has resulted in the enactment of legislation which has had a profound impact through the health care system. The effects of inflationary pressures and of fluctuations in employment levels in the general economy have been felt in the health care sector. We can expect these and other forces for change to continue to operate in the future.

Imbalances arise within the health care system as its elements respond to varied and often conflicting external forces. There has been growing pressure for governmental and private intervention to correct such imbalances. It is thus imperative that policy makers and the public have data which accurately delineates our health care situation.

In recognition of this need for statistical information, the 93rd Congress enacted the Health Services Research, Health Statistics, and Medical Libraries Act of 1974 (Public Law 93-353). This act provides for the collection, analysis, and dissemination of statistical data bearing on health status and the health care system. It also requires that the Secretary, DHEW, submit annually to the Congress and the President a report on health care costs and financing, health resources and their utilization, and health status in the United States. The first of these

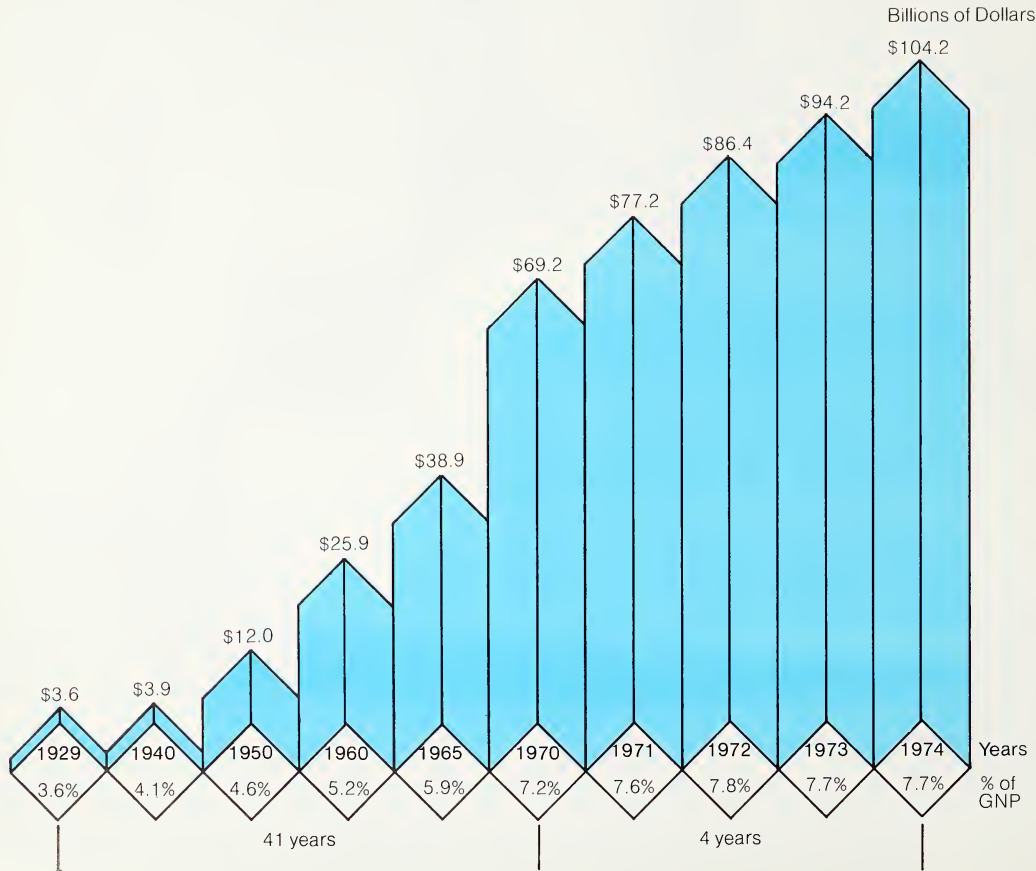
annual reports, *Health, United States, 1975* (DHEW Publication No. (HRA) 76-1232) presents extensive data on each of the four areas, gathered from various public and private sources.

From that detailed report representative data have been selected for presentation in this Chartbook. The intent is to provide a broad overview of national trends and of differentials in health status among our various population groups. The Chartbook, and even the report itself, will not provide all of the data needed by those seeking detailed answers to the highly complex issues of health policy facing the

Nation. Due to both budgetary and technological constraints, certain types of potentially valuable statistical data are not currently available. Furthermore, it is sometimes difficult to assess the long-term significance of newly developing trends in the health sector. However, there are many other important areas of concern for which statistical data can provide considerable clarification of the issues and can contribute to a rational attack on the Nation's health care problems. It is hoped, therefore, that the Chartbook will serve to whet the reader's appetite, and that many readers will go on to the full report and to the more extended treatment given to many of the subject matter areas in reports issued by various governmental and nongovernmental agencies.



National health expenditures and percent of gross national product, selected fiscal years, 1929-1974

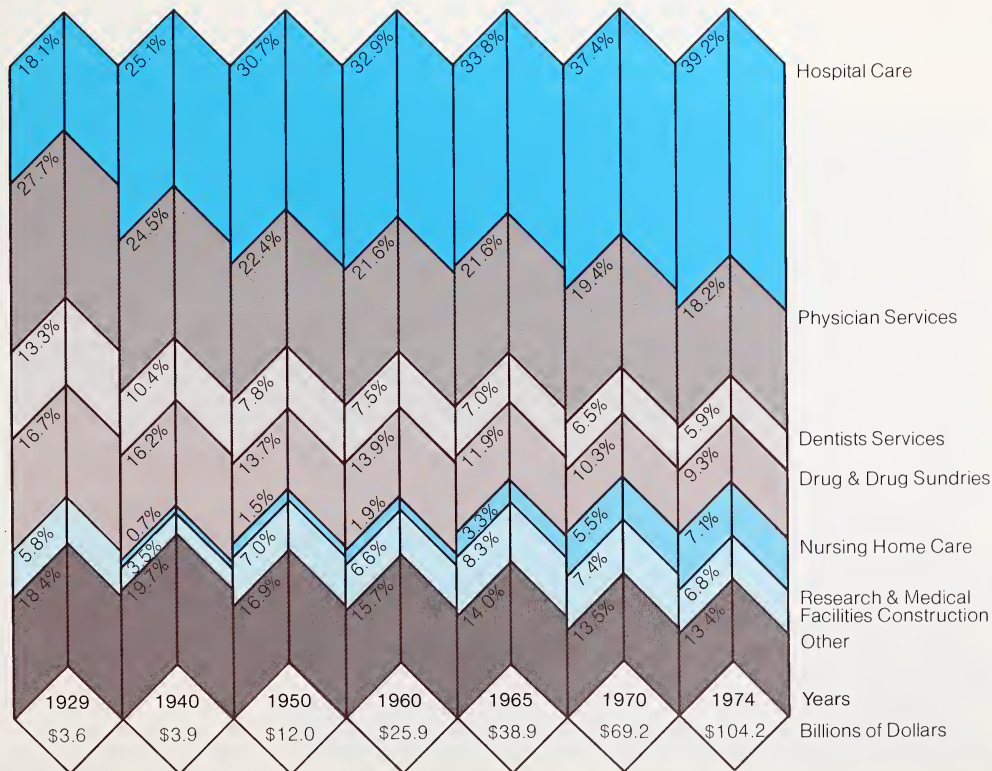


In fiscal year 1974 the United States spent approximately \$104.2 billion for health and medical care—four times the amount spent in 1960, and roughly eight times the amount spent in 1950. In 1965 medical care expenditures totaled \$38.9 billion—5.9 percent of the GNP. The rate of growth in expenditures accelerated with implementation of Medicare and Medicaid in 1966. While during the previous 10 years the average rate of growth had been about 8.0 percent per year, between 1966 and 1971 expenditures grew about 12 percent per year. Between 1971 and 1974 the proportion of GNP accounted for by health care remained steady at approximately 7.7 percent. The rate of growth in expenditures during that period averaged approximately 10 percent per year.

Source: Office of Research and Statistics, Social Security Administration

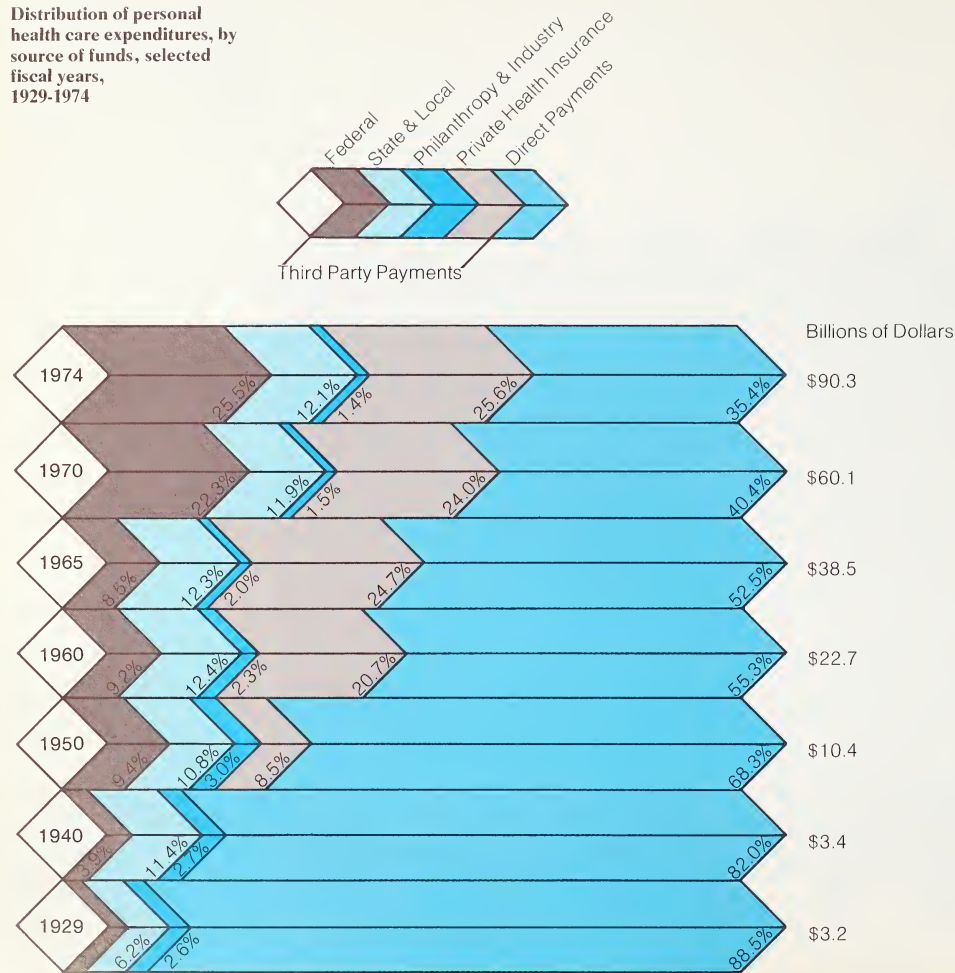
The greatest increase in health expenditures has occurred in the area of hospital care. In 1974 almost 40 percent of all health expenditures were for hospital care compared with 25 percent in 1940. The other area of major growth has been nursing home care, which accounted for less than 1 percent of the expenditures in 1940 while by 1974 it accounted for 7 percent. While the actual number of dollars spent in other areas of health care has increased markedly over the years, the proportion of all health care dollars spent on physicians, dentists, drugs and other services has decreased due to the large increases in hospital and nursing home care.

Percent distribution of aggregate national health expenditures by type of expenditure, selected fiscal years, 1929-1974



Source: Office of Research and Statistics, Social Security Administration

Distribution of personal health care expenditures, by source of funds, selected fiscal years, 1929-1974

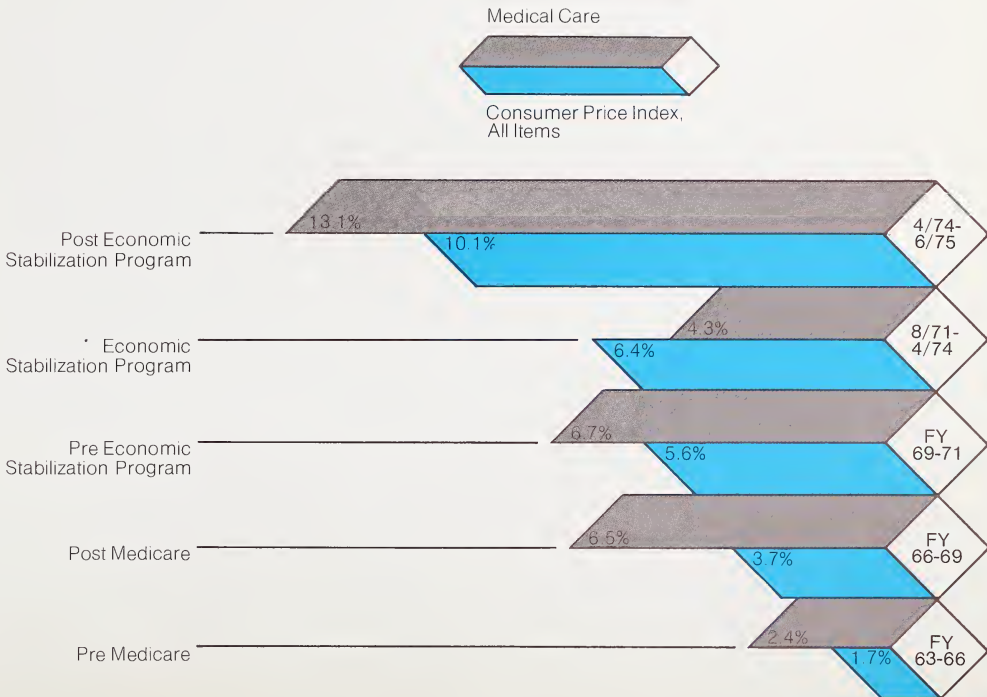


The sources of health funds have shifted drastically over the past half century. The Federal government provided less than 10 percent of all funds up until the implementation of the Medicare and Medicaid programs in the mid-1960's, when the proportion of Federal dollars increased rapidly to 25 percent of all health funds. The contributions from private health insurance have also grown from less than 10 percent of the health dollars in 1950 to 25 percent by 1974. Since 1950, direct payments by individuals decreased from two-thirds to one-third of personal health expenditures; however, since the total personal health expenditures have increased almost nine-fold over that period, the amount of dollars involved in direct payment by individuals has increased from \$7 billion to \$32 billion.

Source: Office of Research and Statistics, Social Security Administration

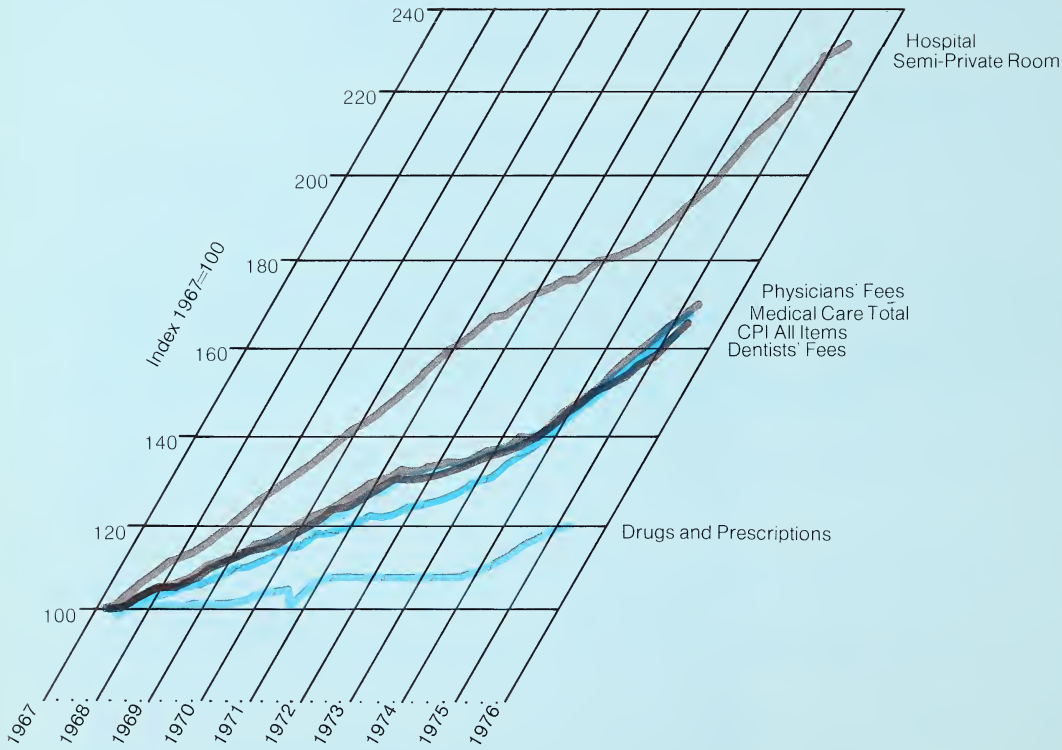
Medical care prices rose at an annual rate of 13.1 percent during the 15 months since the Economic Stabilization Program compared with only 4.3 percent during the Program. During the Economic Stabilization Program medical care prices increased at a slower rate than did the total Consumer Price Index. Medical care prices rose at a faster rate than the total Consumer Price Index both immediately before and after the Economic Stabilization Program.

Average annual percent increase in the Consumer Price Index and medical care prices, selected periods, 1963-1974.



Source: Office of Research and Statistics, Social Security Administration

Quarterly index of consumer
and medical care prices,
1967-1975

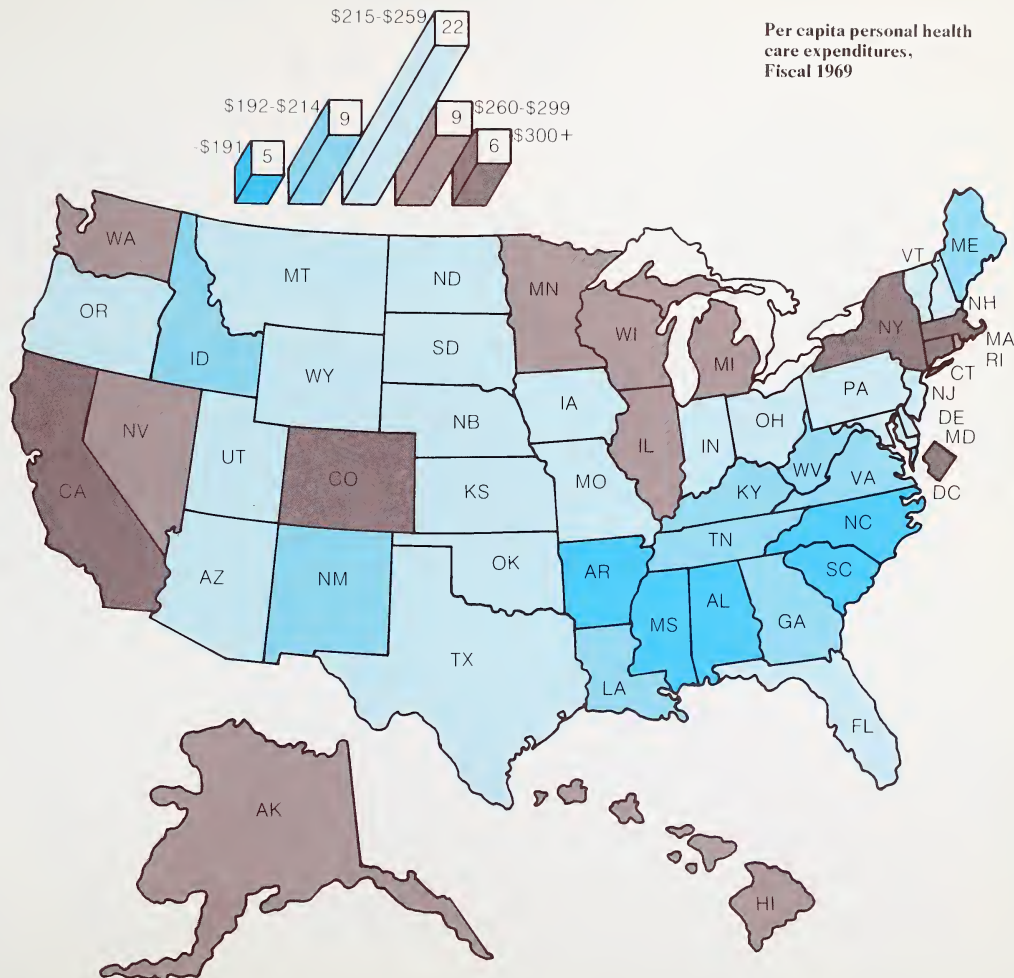


The hospital component of medical care prices has been rising at a faster rate than physician fees and drugs and prescriptions. In fact, the hospital component—the cost of a semiprivate room—has more than doubled over the past 8½ years. The increase in physician fees has been at about the same rate as total medical care prices, while there has been only a slight increase in the cost of drugs and prescriptions.

Source: Office of Research and Statistics, Social Security Administration

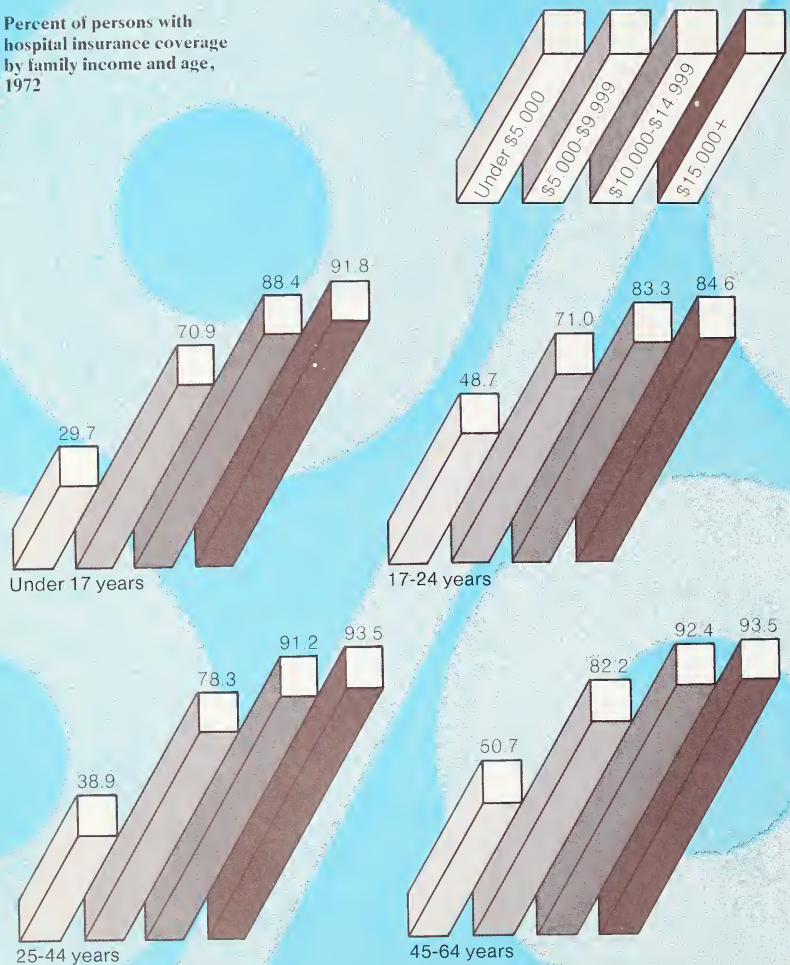
The per capita personal health expenditure for the total United States was \$257 in 1969 (the latest year for which State estimates are available). The 1974 estimate was \$420. Per capita expenditures in 1969 by State ranged from \$138 to \$346. States with low per capita personal health expenditures are, for the most part, located in the South.

Per capita personal health care expenditures, Fiscal 1969



Source: Office of Research and Statistics, Social Security Administration

Percent of persons with hospital insurance coverage by family income and age, 1972

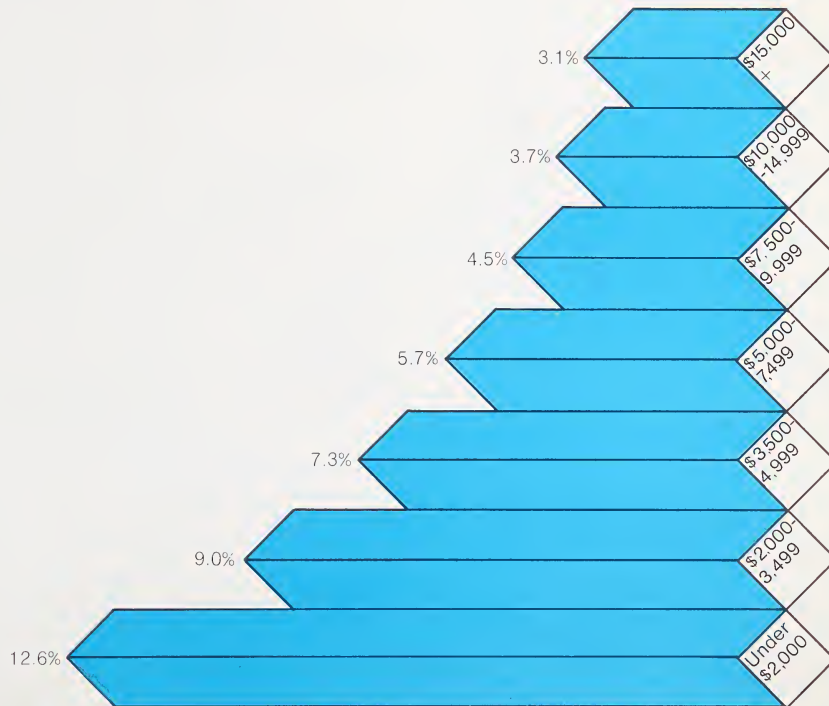


In 1972 approximately 76.7 percent of the population under 65 years of age had private health insurance of some type. However, there are marked differences by income level in the proportion of the population with insurance; for example, among persons 45-64 years of age, only one-half of those in families with less than \$5,000 have health insurance while over 90 percent of those in families with incomes over \$10,000 have insurance. Almost all persons 65 years and over are eligible for hospital benefits under the Medicare program.

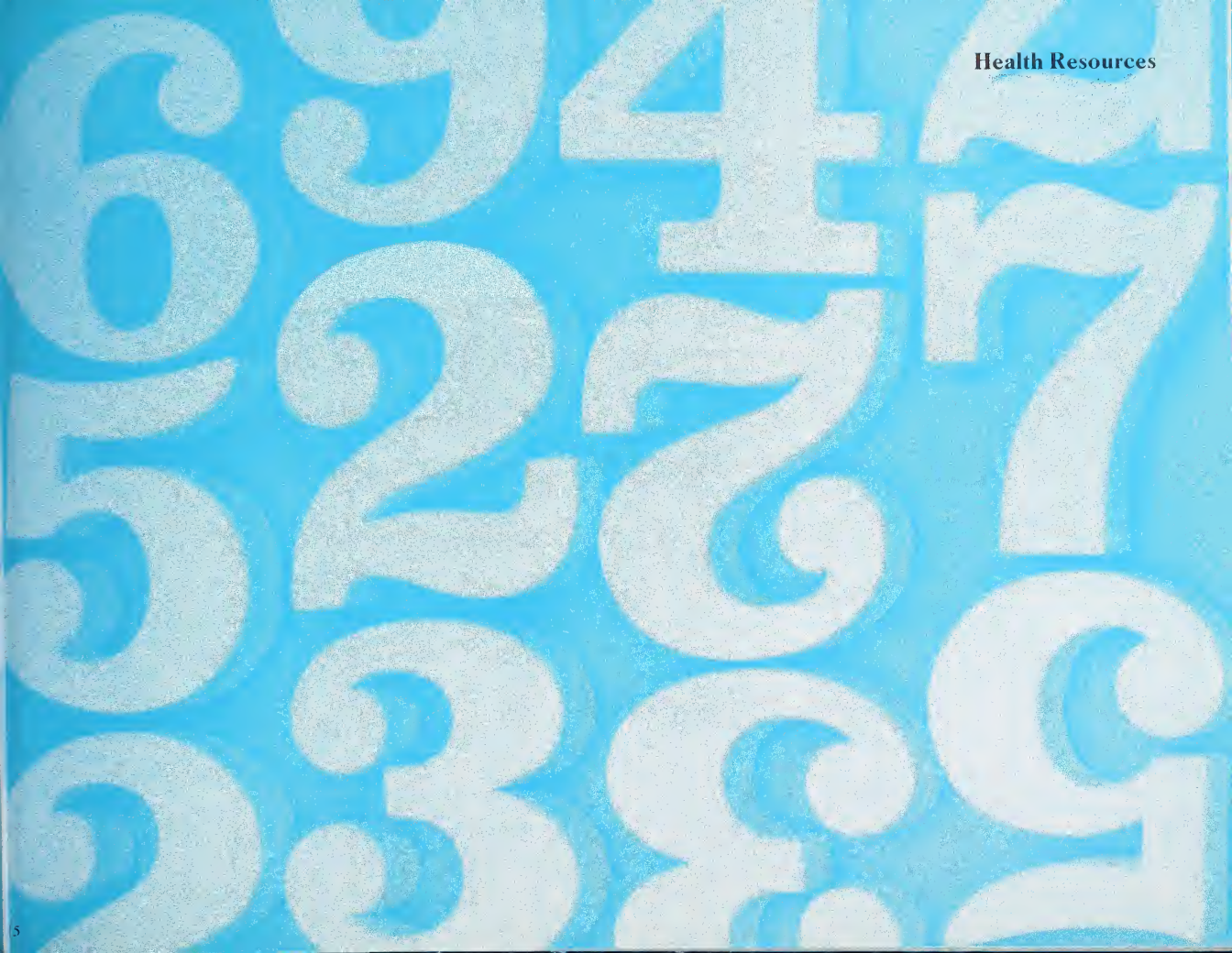
Source: Health Interview Survey, National Center for Health Statistics

Direct payments by families for health care (including health insurance premiums) take a disproportionate share of the income from low-income families. Data for 1970 indicate that in the aggregate, families with less than a \$2,000 income spent over 12 percent of their incomes on health care and health insurance premiums compared with only 3 percent spent by families with over \$15,000 incomes.

Percent of family income paid out-of-pocket for medical expenses by family income, 1970

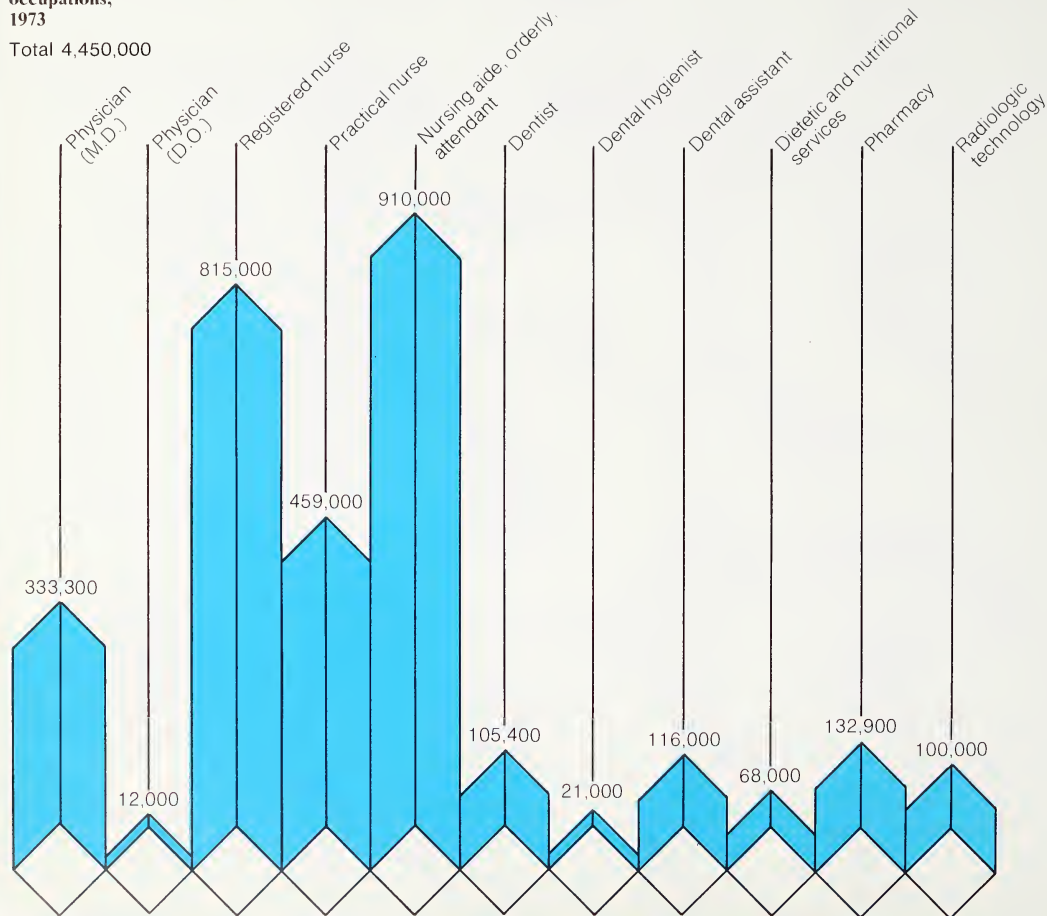


Source: Center for Health Administration Studies, University of Chicago



**Estimated number of persons
active in selected health
occupations,
1973**

Total 4,450,000

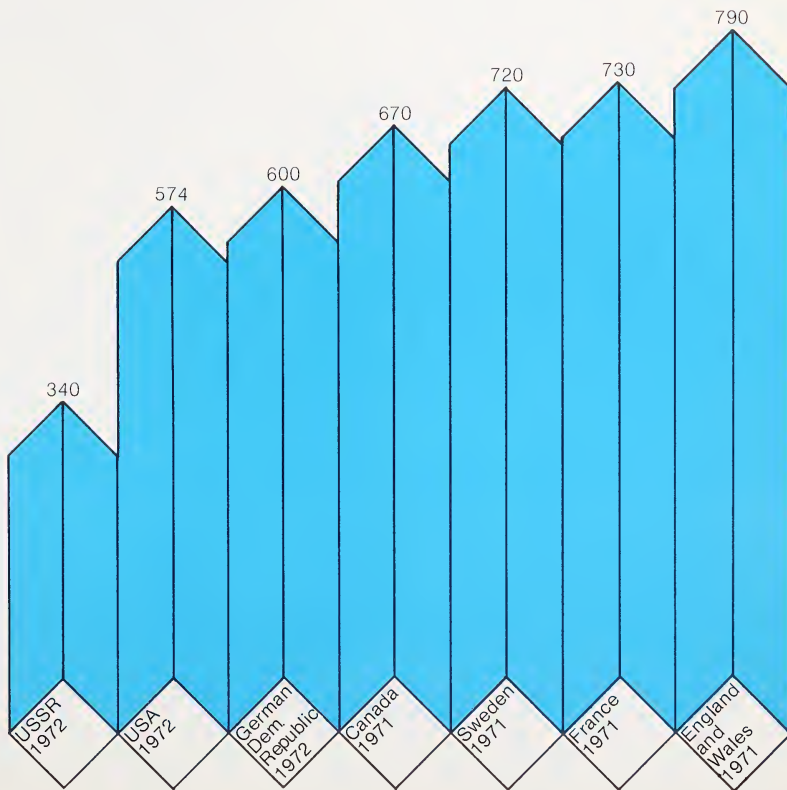


In 1973 there were an estimated 4.4 million persons employed in health-related occupations; one-half of these were in nursing or related services. The ability to affect the supply of health manpower through government programs differs markedly by occupation due to the wide range of time required for education and training.

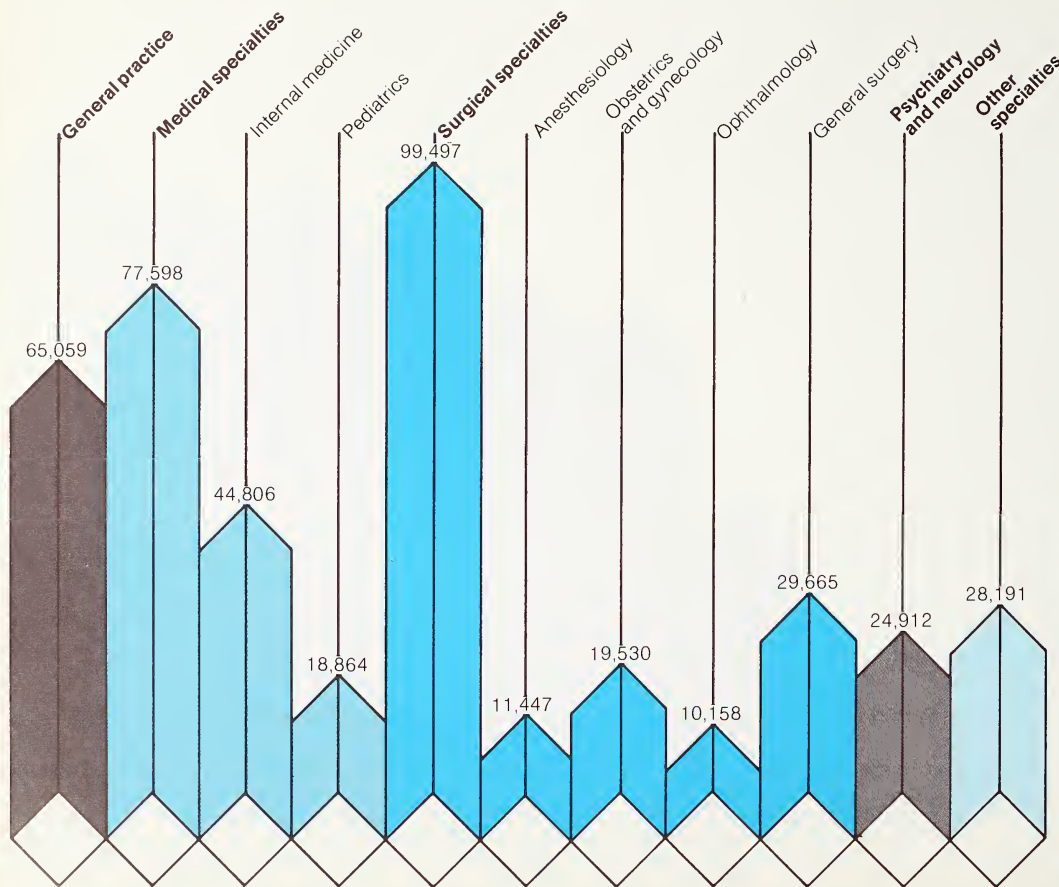
Source: National Center for Health Statistics

The number of persons per physician varies widely among countries. The number of persons per physician is appreciably smaller in the Soviet Union than in the United States, but larger in countries such as Sweden, France, and England and Wales.

Number of persons per physician in selected countries, 1971-1972



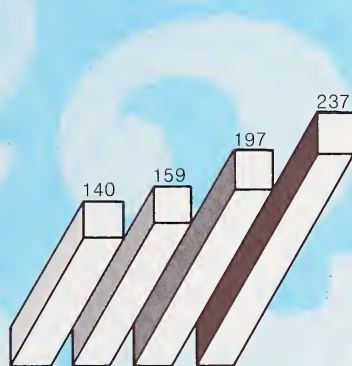
Number of active physicians
(M.D.s) in patient care,
1973



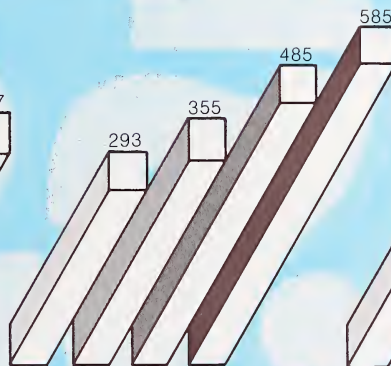
In 1973 there were an estimated 295,000 physicians involved in direct patient care or one physician for approximately every 700 persons (the previous chart included all active physicians). About one-fifth of the doctors providing direct patient care were in general practice, one-quarter were in medical specialties, and one-third were in surgical specialties.

Source: American Medical Association

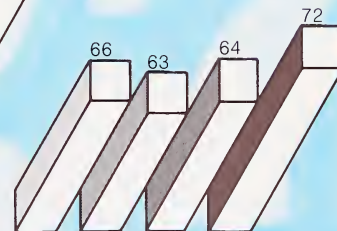
**Supply of active health
professionals,
1960-1990**



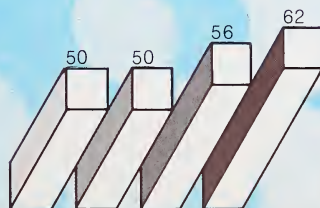
Physicians (M.D. & D.O.)
(Rate per 100,000 population)



Registered Nurses



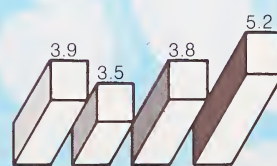
Pharmacists



Dentists



Optometrists



Podiatrists

The greatest projected increases in the number of health professionals are for physicians and registered nurses. The number of registered nurses per 100,000 population is expected to double between 1960 and 1990, and the number of physicians is expected to increase by about 70 percent. While there are projected increases in the number and rate per 100,000 population of dentists, pharmacists, optometrists, and podiatrists, they are not as large as those for physicians and nurses.

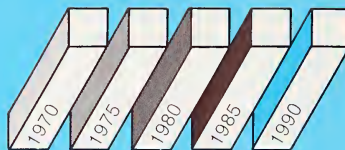
**Projected supply of active
physicians,
1970-1990**



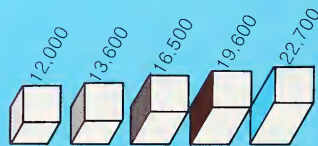
All Active Physicians



Foreign Trained M.D.'s



U.S. Trained M.D.'s

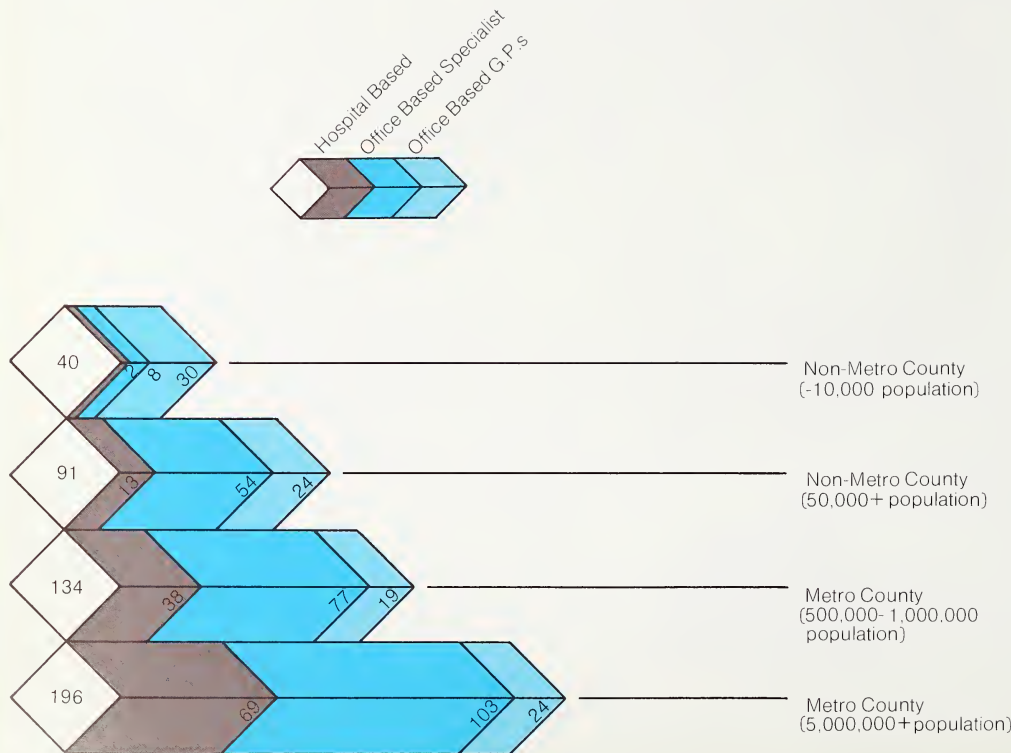


Osteopaths

In recent years, the number of active physicians in the United States has been growing faster than the population as a whole, and thus the physician to population ratio has been increasing. The increase is due partly to the formation of new medical schools and to an increase in the number of admissions by some of the older medical schools, and partly to an appreciable increase in the number of foreign-trained physicians practicing in the United States. Simultaneously, there has been a decline in the rate of growth of the total population. Assuming no marked shift in the size of medical school graduating classes, the flow of foreign medical graduates to the U.S. stock, and the fertility rates of the population, the number of physicians per 100,000 population in 1990 might be as much as 50 percent greater than it is today.

Source: "Supply of Health Manpower" DHEW Pub # (HRA) 75-38

Number of non-federal
physicians per 100,000
population by county size
and type of physician,
1973

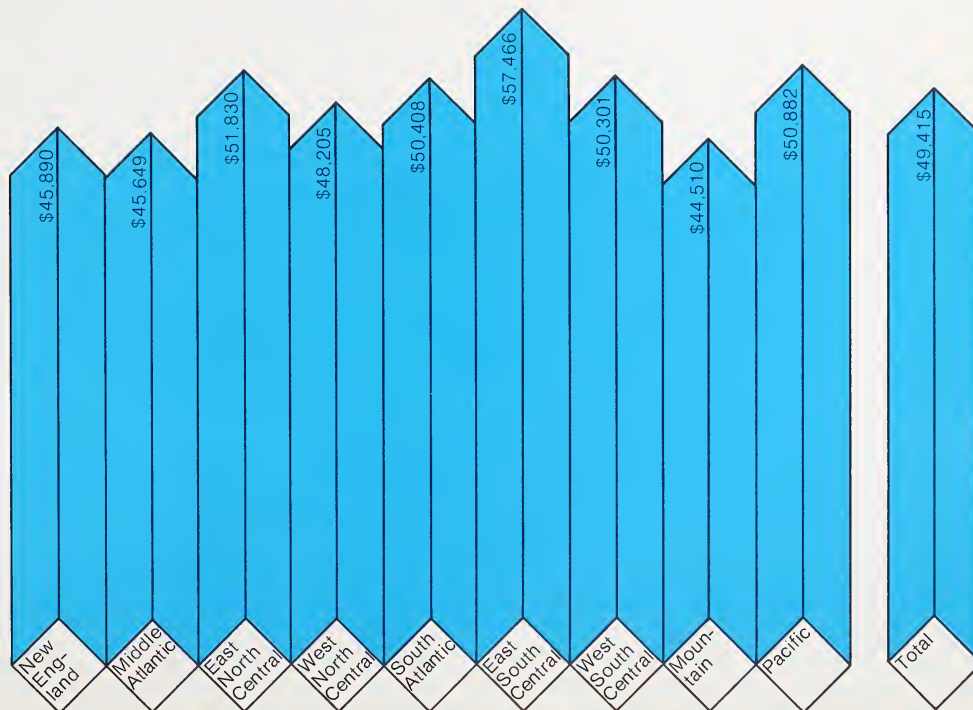


The geographic distribution of physicians is weighted heavily toward metropolitan areas. In 1973, there were approximately 196 nonfederal physicians providing patient care for every 100,000 individuals living in the largest metropolitan areas. The comparable ratio for small nonmetropolitan counties was 40 physicians for every 100,000 residents. With respect to medical specialists, the geographic distribution is even more biased towards the larger metropolitan areas.

Source: American Medical Association

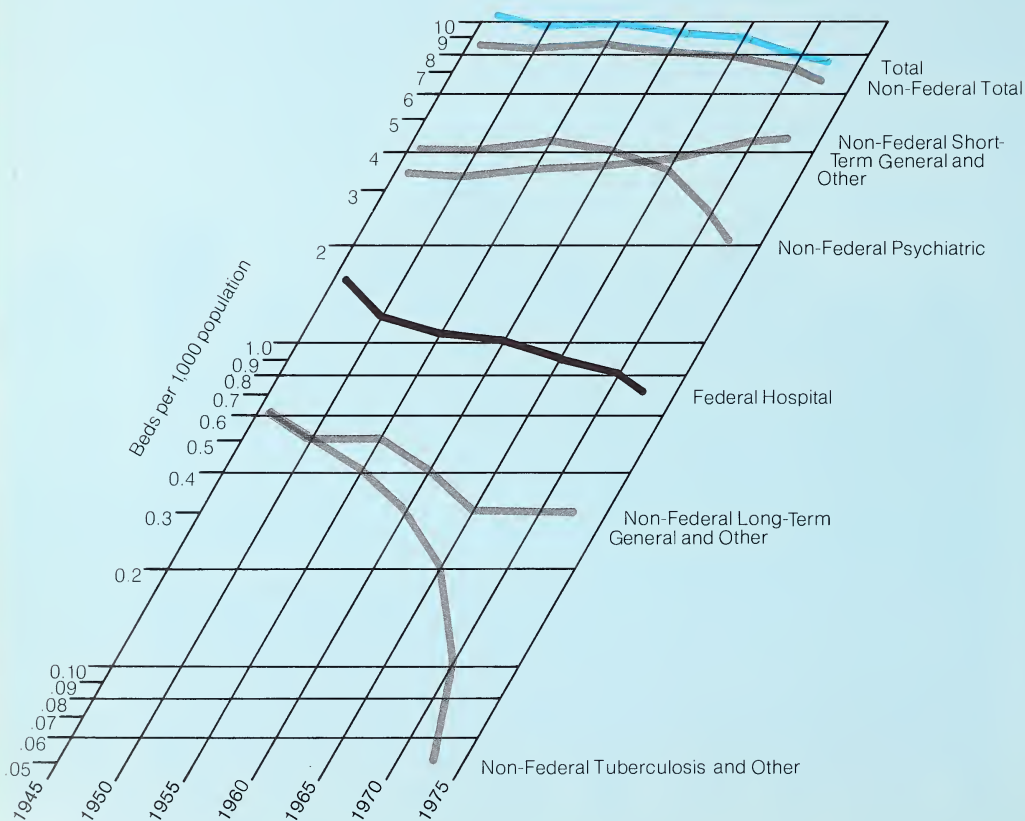
In 1973 the average annual net income of a physician in the United States was \$49,415. There were considerable differences by geographic region. Doctors in the Mountain States had average annual incomes of approximately \$44,500 compared with more than \$57,000 for doctors in the East South Central States.

Average net income of physicians by census division, 1973



Source: American Medical Association

**Number of hospital beds per
1,000 population by type of
hospital,
1946-1973**



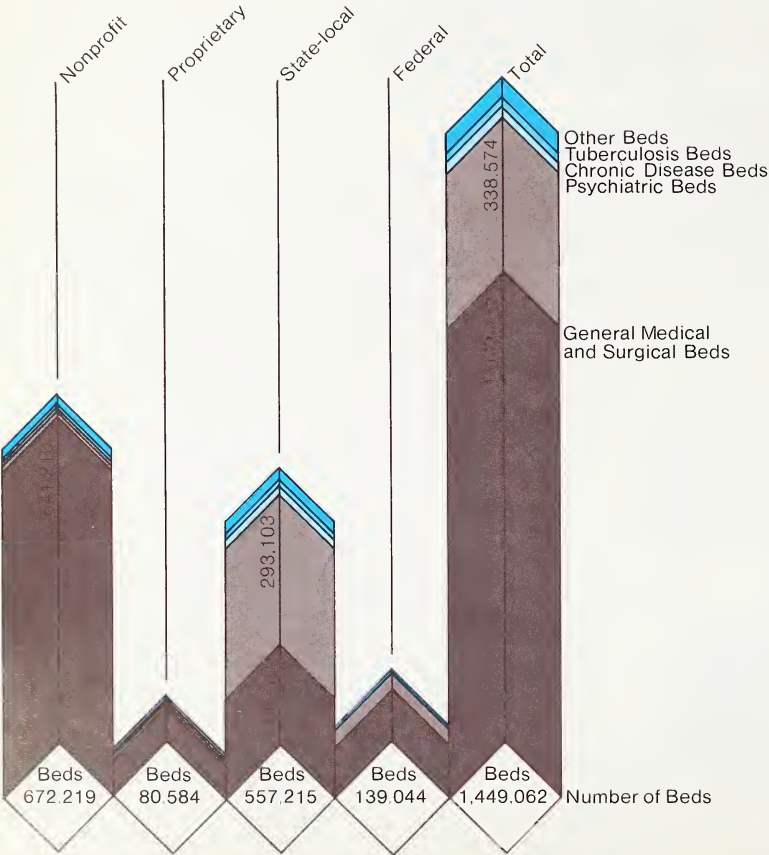
Since 1946 the number of hospital beds of all kinds per 1,000 population has decreased from 10.3 to 7.3. The decrease has occurred in federal hospitals and in nonfederal psychiatric, tuberculosis and other long-term hospitals. At the same time there has been an increase in the number of beds in short-term general hospitals, primarily as the result of the Hill-Burton program.

Source: American Hospital Association

Source: National Center for Health Statistics



Number of hospital beds by ownership of hospitals, 1973

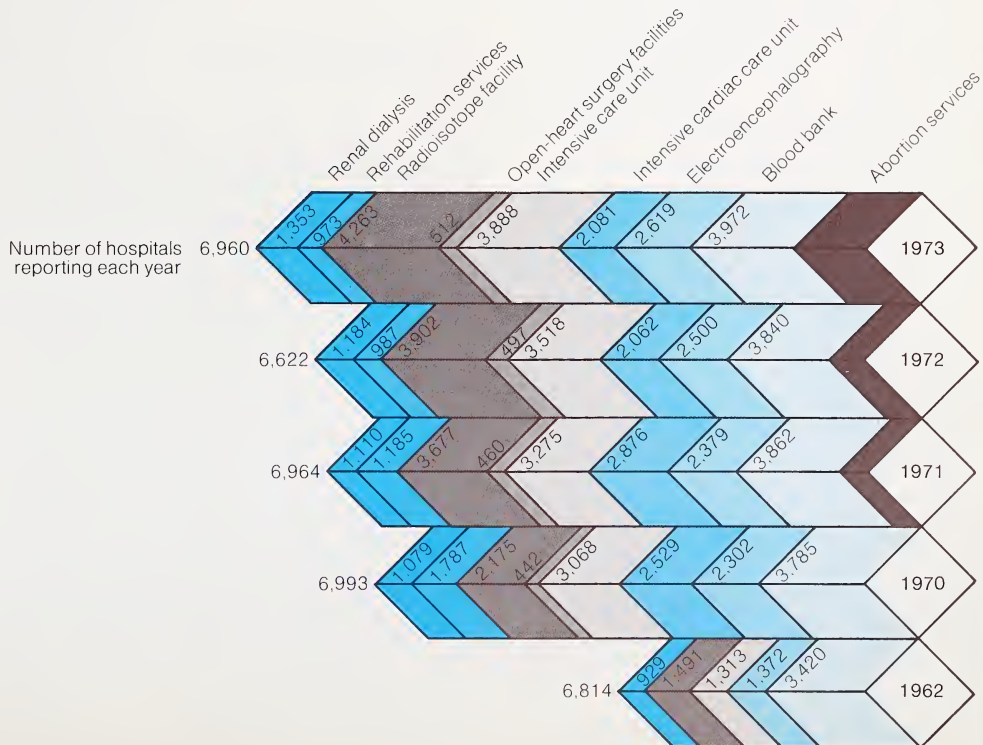


About two-thirds of the beds for general medical and surgical patients are in private nonprofit hospitals. A vast majority of psychiatric hospital beds are in State or local government hospitals.

Source: National Center for Health Statistics

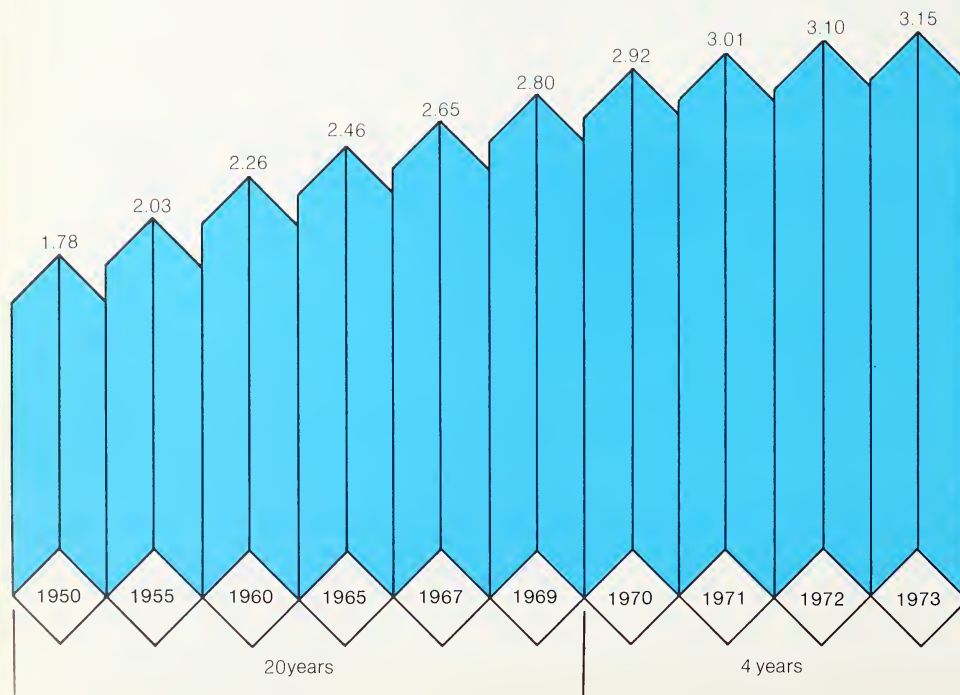
The range of services offered by hospitals has been increasing in recent years. Certain types of services such as renal dialysis or abortion were virtually unavailable a decade ago. In 1962 less than 25 percent of hospitals had a radioisotope facility, while by 1973 over 60 percent of the hospitals had such services. This increase in the types of services offered by individual hospitals has been a factor in the rapid growth in expenditures for hospital care.

Number of hospitals reporting services for selected years, 1962, 1970, 1971, 1972, 1973



Sources: American Hospital Association and National Center for Health Statistics

Number of employees per patient¹ in non-federal short-term general hospitals, selected years, 1950-1973.



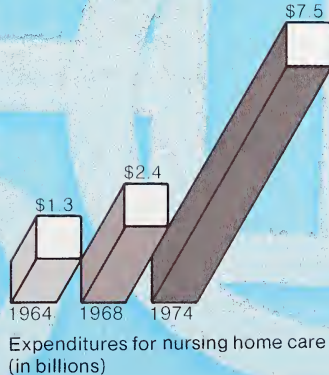
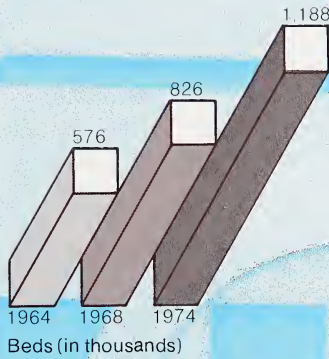
The total number of employees in short-stay general hospitals has increased markedly since 1950. In 1973, hospitals had the equivalent of more than three full-time employees for every bed occupied on an average day. While this is in part due to the great increase in the provision of ambulatory services by hospitals, it also reflects the increasing complexity of inpatient services and changing staffing patterns.

¹full-time equivalent employees per daily census

Source: American Hospital Association

The number of nursing home beds has doubled in the past 10 years from 576,000 beds in 1964 to 1,188,000 beds in 1974. The number of employees per 100 nursing home residents has also increased, from 47 to 66 per 100 residents. Since 1964, total expenditures for nursing home care have increased more than fivefold. While cost inflation, expansion in the range of services, and growth in the number of elderly in the population account for most of the increase in expenditures for nursing home care, part of the increase is the result of the present substitution of care within nursing homes for care which previously had been provided in mental hospitals and other settings.

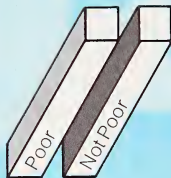
Selected nursing home data,
1964, 1968, 1974



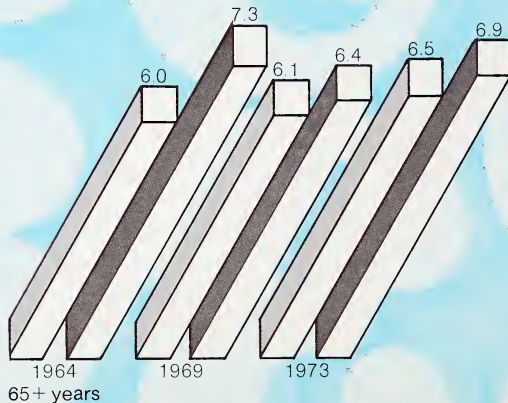
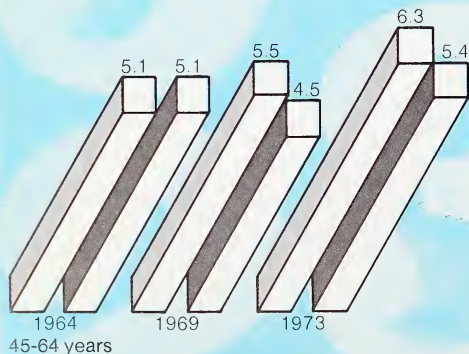
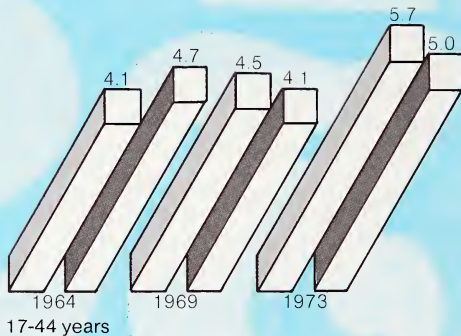
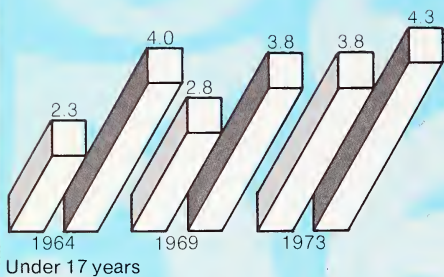
Source: Office of Research and Statistics, Social Security Administration



Number of outpatient physician visits per person per year by poor and not poor status and age, 1964, 1969, 1973

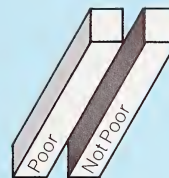
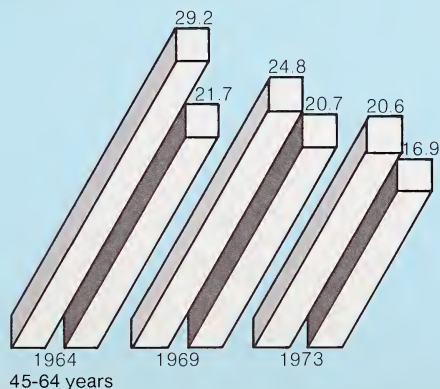
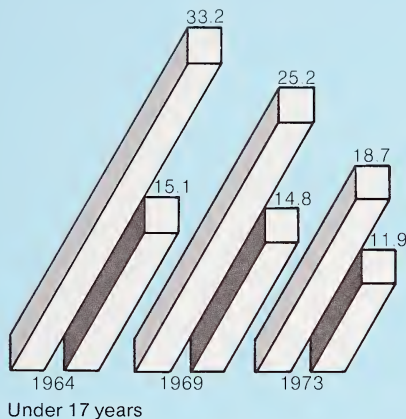


The number of doctor visits per person per year has increased over the past decade. The major increase has occurred among the poor. In 1964 the poor reported considerably fewer doctor visits than did the not poor, while by 1973 these differences had decreased markedly or had reversed. It is presumed that these changes in patterns between the poor and the not poor reflect to some extent the impact of federal programs such as Medicare and Medicaid.

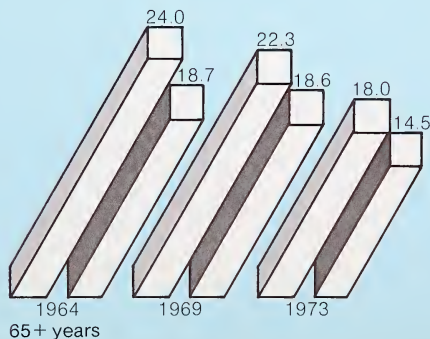
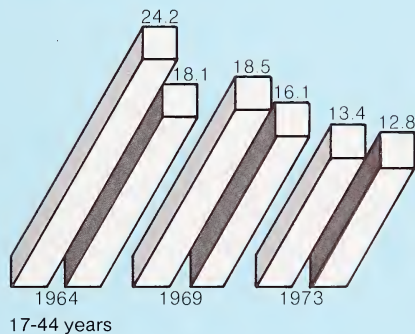


Source: Health Interview Survey, National Center for Health Statistics

During the past decade the proportion of the population who had not seen a physician within the past 2 years has decreased. The biggest decreases occurred among the poor; for example, in 1964 one in three poor children had not seen a doctor in the past 2 years, but by 1973 this figure had dropped to less than one in five. However, there are still slight differences between the poor and the not poor, with fewer poor persons seeing doctors.

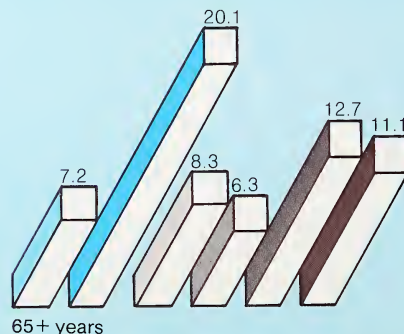
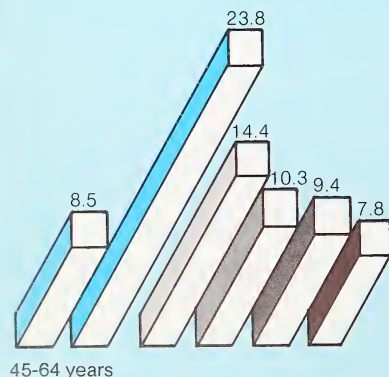
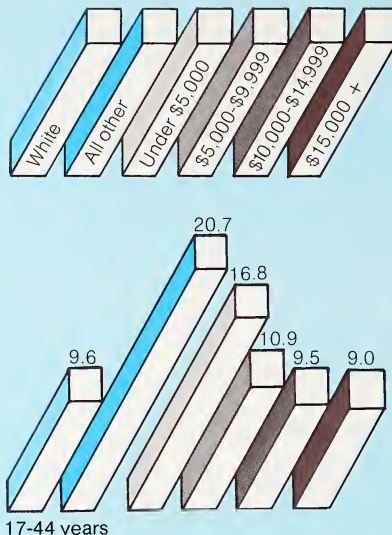
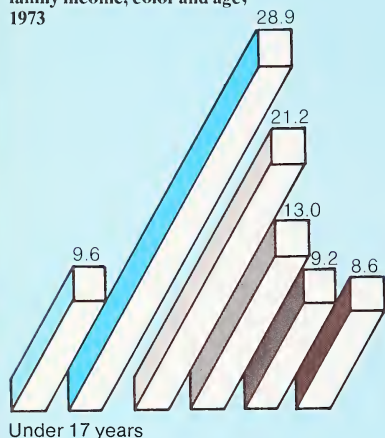


Percent of the population who have not seen a physician within the past 2 years by poor and not poor status and age, 1964, 1969, 1973



Source: Health Interview Survey, National Center for Health Statistics

Percent of all outpatient physician contacts¹ that occur at hospital outpatient clinics or emergency rooms, by family income, color and age, 1973



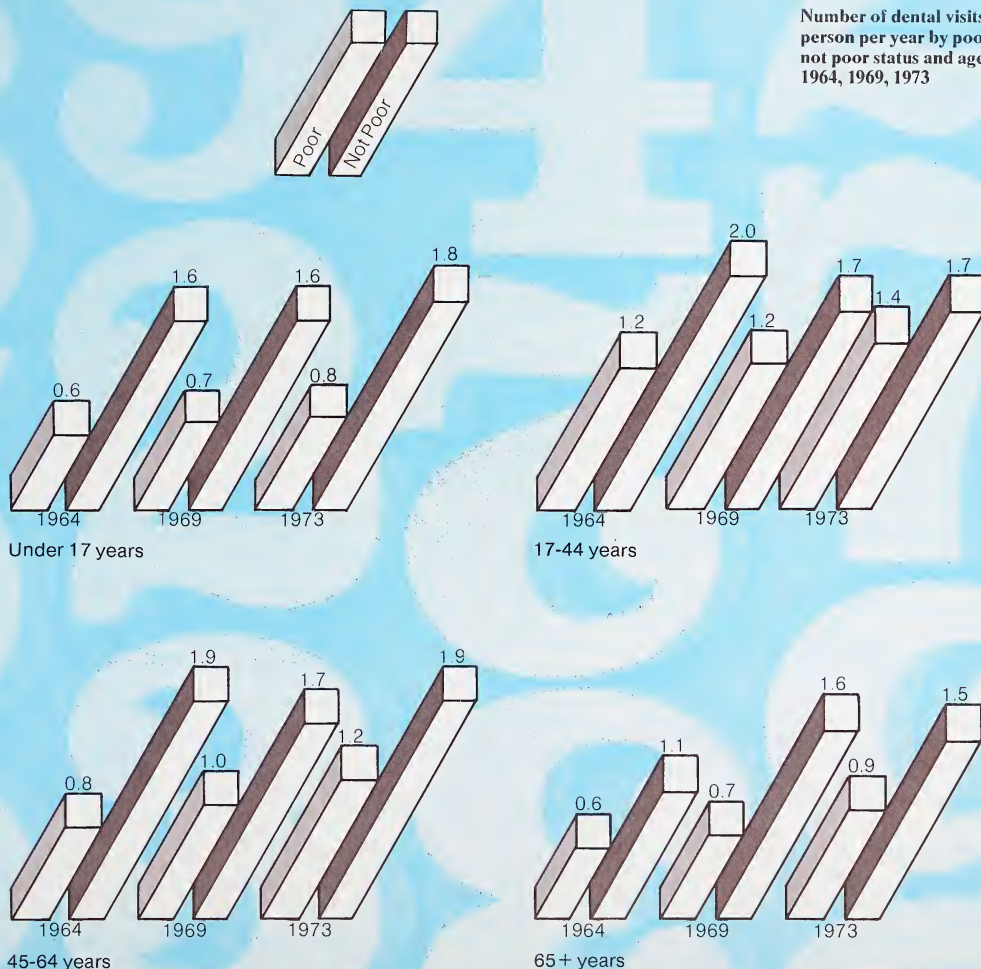
Approximately 10 percent of all physician contacts, other than those of hospital inpatients, occur at hospital outpatient clinics or emergency rooms. The use of these types of facilities varies by color and family income. While 10 percent of the visits among white children take place at hospital clinics and emergency rooms, nearly 30 percent of the visits among minority children occur at such places. There are similar differences by family income, with persons in low income families generally using hospital outpatient clinics and emergency rooms more frequently than persons with higher family incomes.

¹includes offices, telephone advice, home, industrial clinics

Source: Health Interview Survey, National Center for Health Statistics

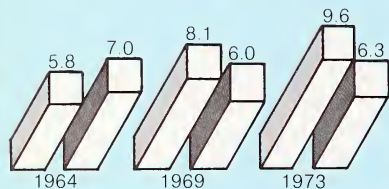
The number of dental visits per person per year has generally been increasing among the poor over the past decade. However, the poor still make considerably fewer dental visits than do the not poor. This is in contrast to the changing patterns of physician visits, where the poor-not poor differences have decreased markedly or reversed.

Number of dental visits per person per year by poor and not poor status and age, 1964, 1969, 1973

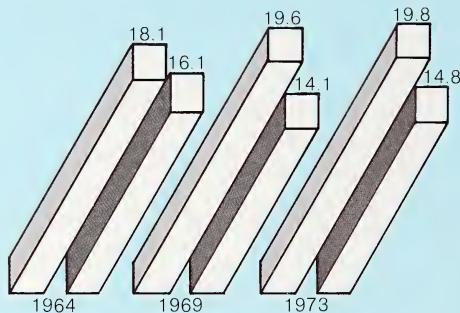
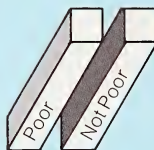


Source: Health Interview Survey, National Center for Health Statistics

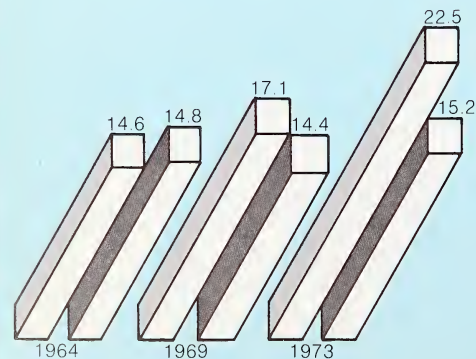
Number of discharges from short-stay hospitals per 100 persons per year by poor and not poor status and age, 1964, 1969, 1973



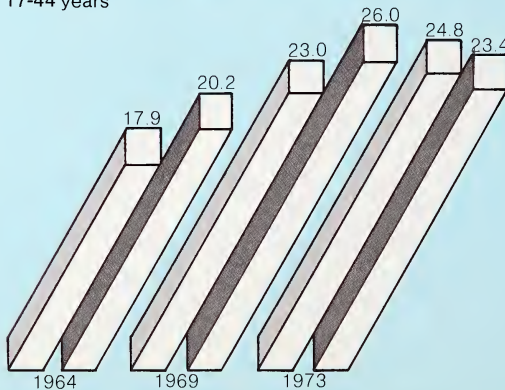
Under 17 years



17-44 years



45-64 years

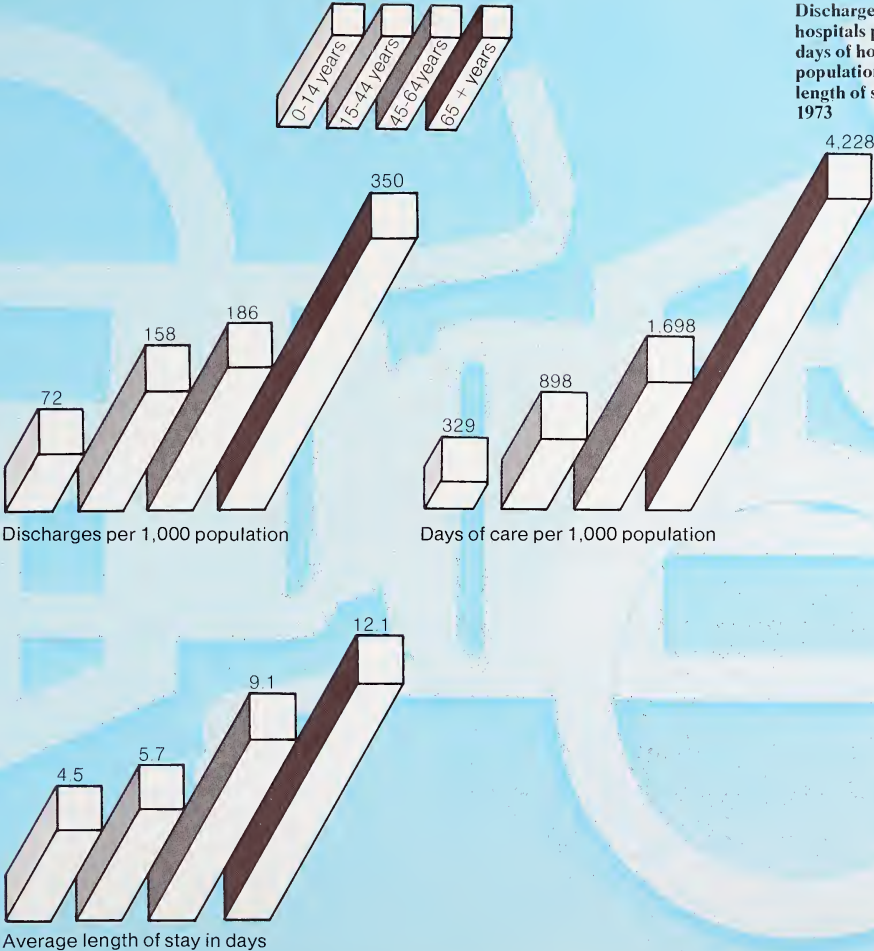


65+ years

The number of hospitalizations per 100 person has increased markedly among the poor over the past decade, reflecting to a large extent the increased access made available through the Medicaid and Medicare programs. Among the not poor, there has been relatively little change in hospital utilization among the children and young adults and only relatively small increases among the elderly.

Source: Health Interview Survey, National Center for Health Statistics

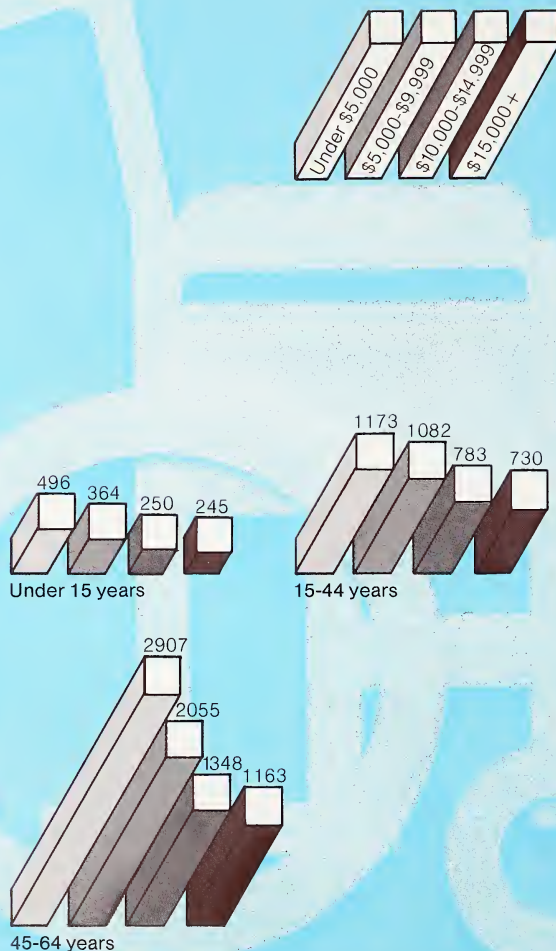
For every 1,000 persons in the civilian, noninstitutionalized population there are 160 discharges from short-stay hospitals and 1,238 days of care during the year. The average patient stays in the hospital just over a week. The rate of hospitalization, the number of days per 1,000 persons, and the average length of stay per patient all increase with increasing age.



Discharges from short-stay hospitals per 1,000 population, days of hospital care per 1,000 population, and average length of stay by age, 1973

Source: Hospital Discharge Survey and the Health Interview Survey, National Center for Health Statistics

Number of days of hospital care per 1,000 population by income and age, 1973



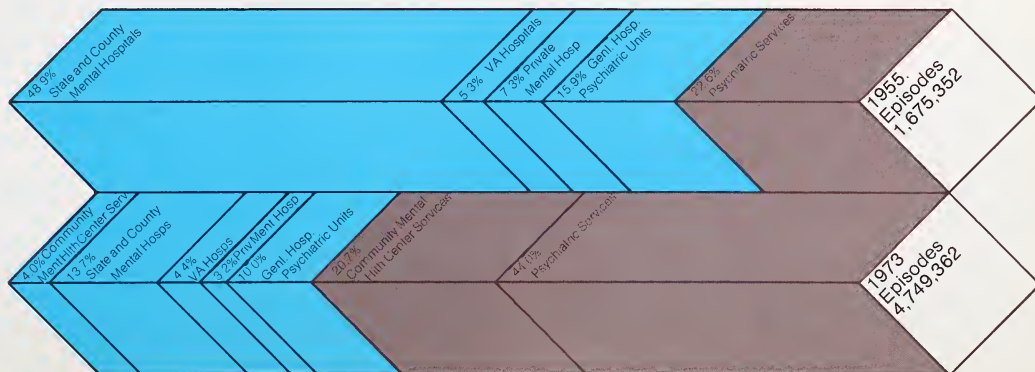
The number of short-stay hospital days per 1,000 persons decreases with family income. For example, children in high income families have only half the hospital days that children in low income families have and low income adults ages 45-64 have two and a half times as many hospital days as do high income middle-aged adults. The increased hospital utilization among the poor adults reflects the complex relationship between illness and family income, e.g. family income often decreases as a result of serious illness.

Source: Hospital Discharge Survey and the Health Interview Survey, National Center for Health Statistics

The number and rate per 100,000 population of patient care episodes in mental health facilities nearly tripled between 1955 and 1973, with almost the entire increase being outpatient episodes. Inpatient episodes in state and county mental hospitals accounted for only 14 percent of all episodes in 1973 compared with almost half the episodes in 1955.

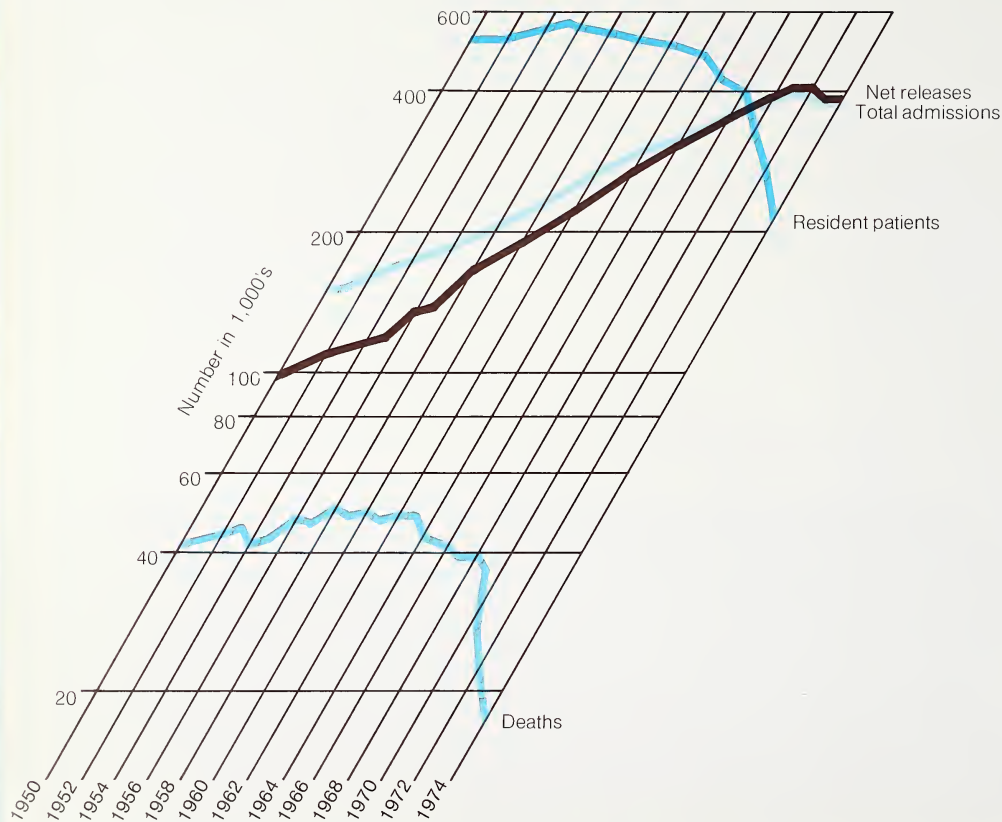


Percent distribution of inpatient and outpatient care episodes in selected mental health facilities by type of facility, 1955 and 1973



Source: National Institute of Mental Health

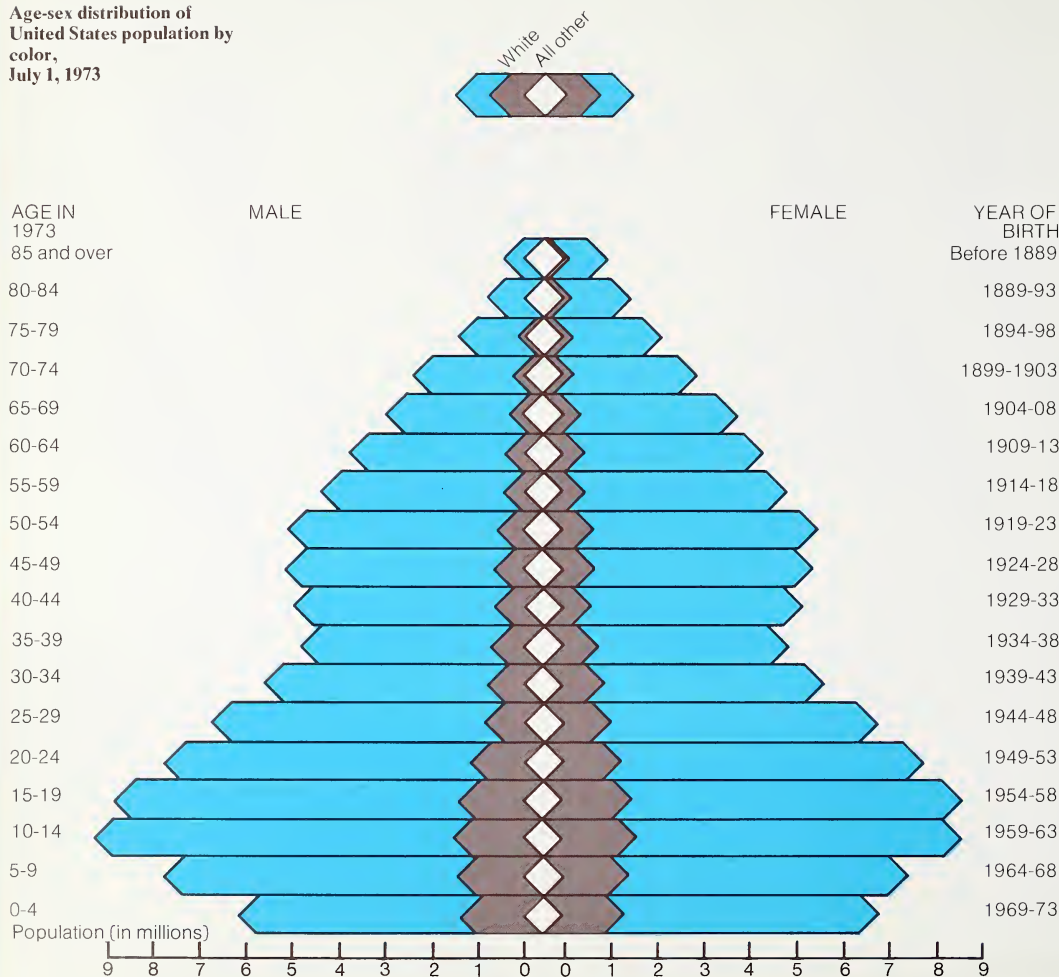
Number of resident patients,
total admissions, net releases
and deaths, State and county
mental hospitals,
1950-74



The number of resident patients in mental hospitals decreased for the first time between 1955 and 1956 and the decrease continued each year thereafter, with an acceleration of the decline beginning in the mid-1960's. This was a result of shorter episodes of hospitalization and more multiple periods of admissions. Thus, total admissions continued to increase until 1971 after which they began to decline.

Source: Division of Biometry,
National Institute of Mental
Health

Age-sex distribution of
United States population by
color,
July 1, 1973

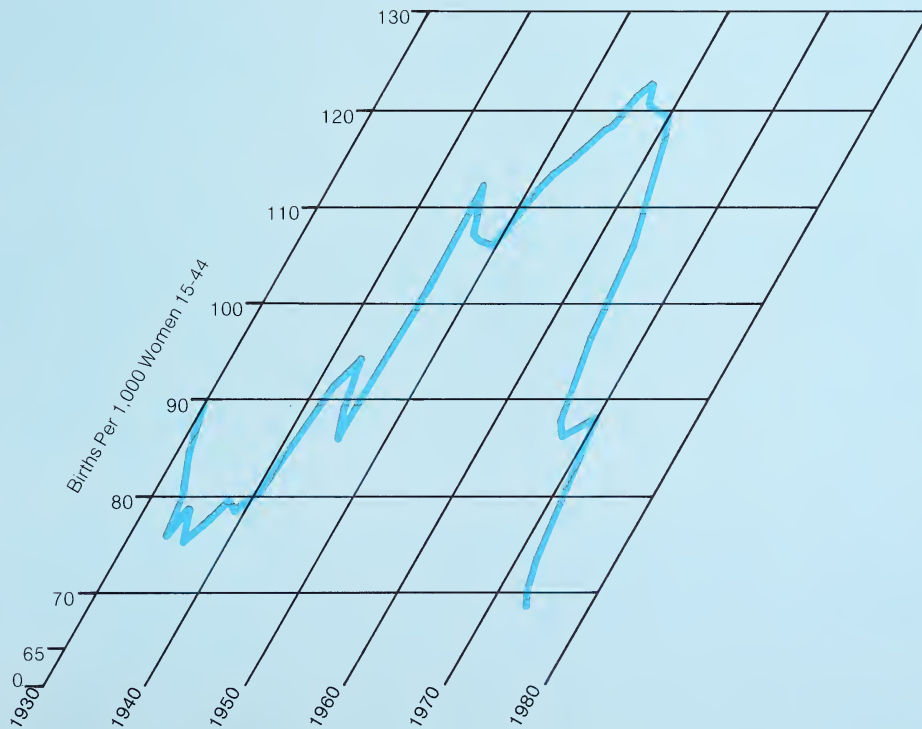


The effects of the low birth rate of the 1930's, of the post-World War II "baby boom," and of the recent decline in fertility are all clearly visible on the age-sex population pyramid. The greater longevity of females has resulted in the markedly larger number of females than males in the older age groups.

Source: U.S. Bureau of the Census

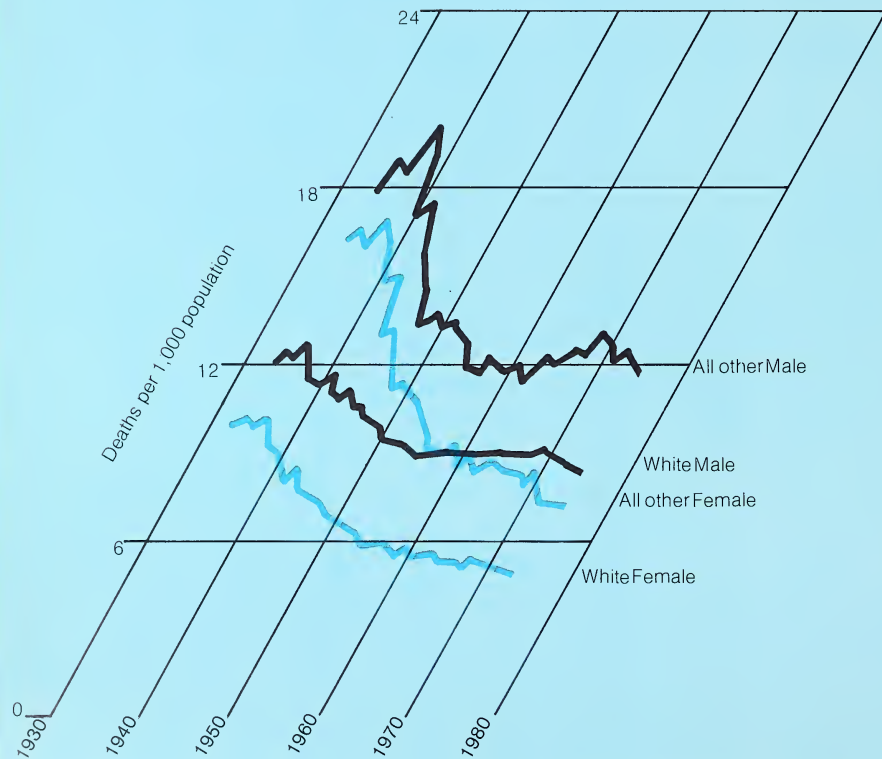
The number of births per 1,000 women in the child-bearing ages has declined with little interruption since 1957 to a point well below the level prior to World War II. In 1974 the number of births per 1,000 women ages 15-44 was only 56 percent of the rate in 1957 and is at a record low.

Number of births per 1000 women ages 15-44, 1930-1974



Source: National Center for Health Statistics

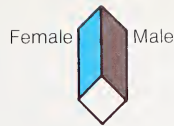
Age-adjusted death rates, by
color and sex,
1933-73



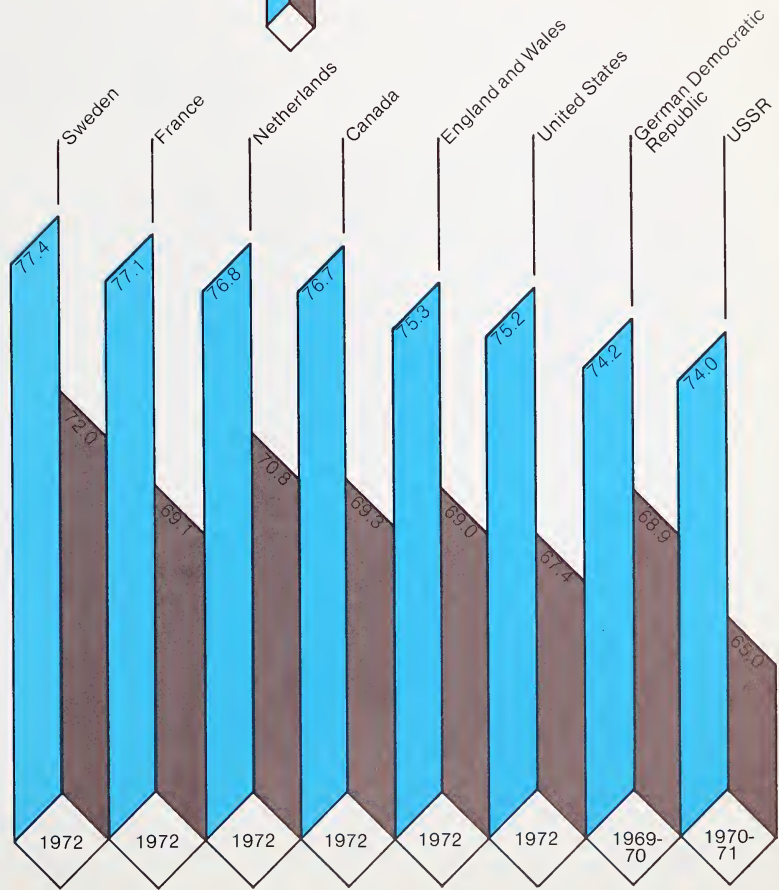
Death rates in the United States declined rapidly from the mid-1930s to the mid-1950's, at which time the death rates leveled off. They began to decline again a decade later. Wide differences in mortality still remain among various subgroups of the population. The age-adjusted death rate for males is 80 percent higher than the rate for females. The age-adjusted death rate for other than white males is more than one-third greater than the rate for white males; the rate for other than white females is half again as great as the rate for white females.

Source: National Center for Health Statistics

Life expectancy in 1972 was longer in a number of countries than in the United States. Swedish females' life expectancy was approximately 2 years longer than U.S. females', while life expectancy for Swedish males was more than 4 years greater than that for U.S. males.



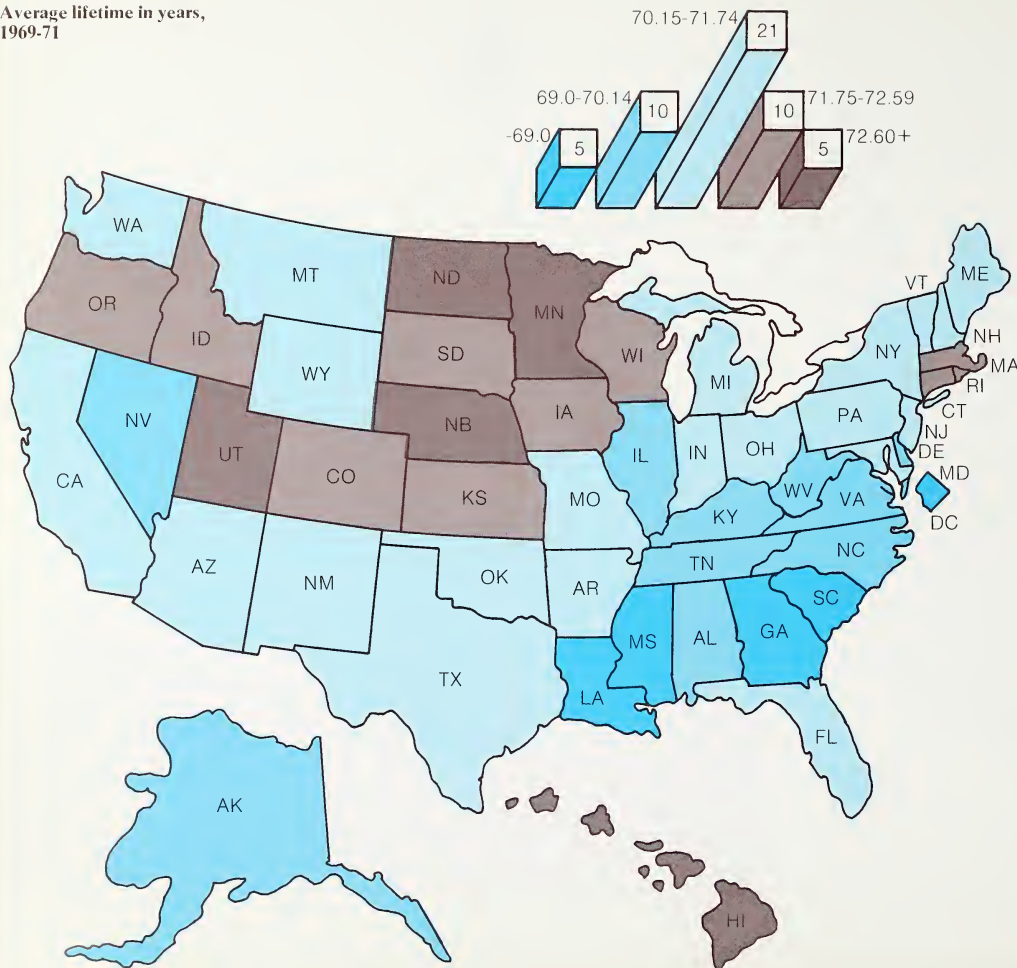
Life expectancy at birth by sex for selected countries



Scale begins at approximately 60 years of age.

Source: World Health Organization

Average lifetime in years,
1969-71

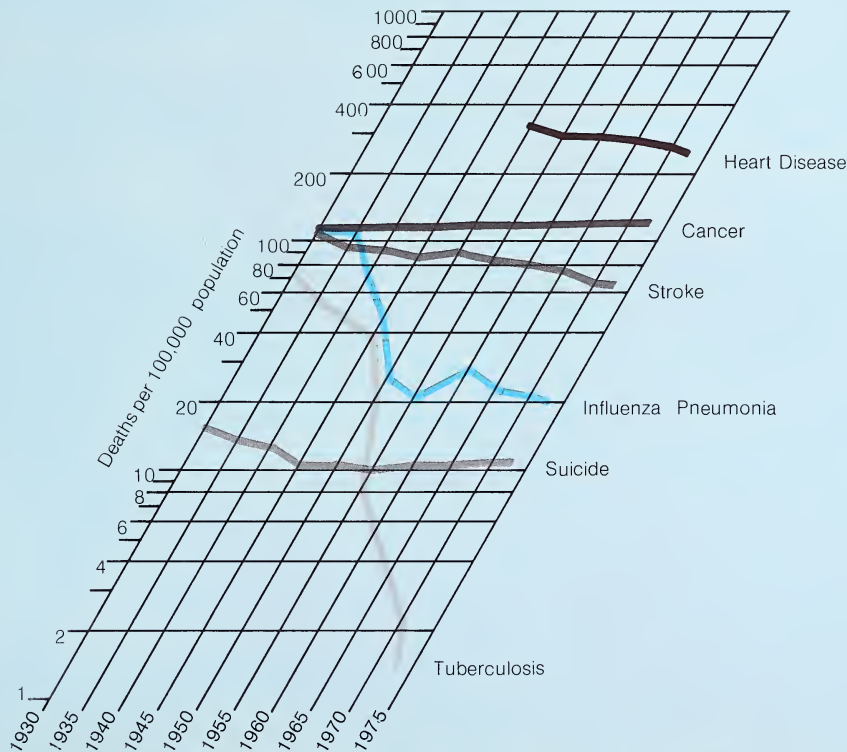


In the United States the longest life expectancy is found in some of the upper Midwestern and Mountain States. The lowest life expectancy is found in the Southern and Appalachian States. The relationship between life expectancy and health resources is not clear; some States with low physician-population ratios have life expectancies which are among the shortest while other States with low physician-population ratios have life expectancies among the longest.

Source: National Center for Health Statistics

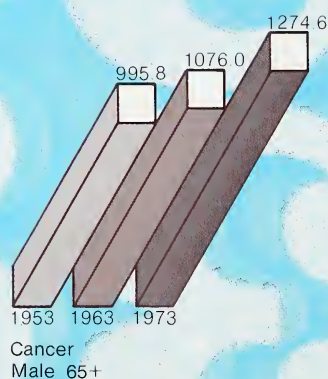
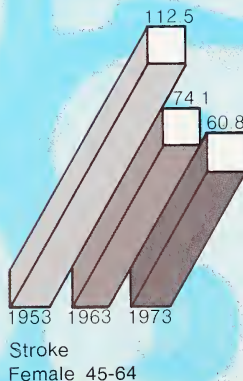
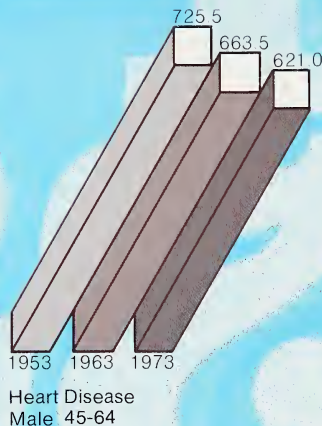
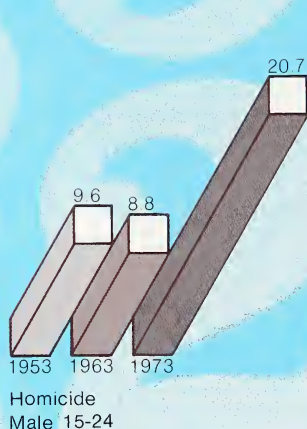
Age - adjusted death rates for
selected causes,
1930-1973

Death rates from most causes have been decreasing although there are sharp contrasts between diseases. Spectacular declines have occurred for influenza and tuberculosis. Stroke and heart disease deaths have been dropping more slowly, while death rates from cancer and suicide have increased slightly during the recent past.



Source: National Center for
Health Statistics

Death rate per 100,000
population for selected
causes, by sex and age,
1953, 1963, 1973



The recent changes in mortality are particularly marked among selected diseases and within certain age and sex groups. Deaths related to heart disease have declined among middle-aged males and deaths from strokes have dropped markedly among middle-aged females. A major increase has occurred in the homicide rate for young adult males.

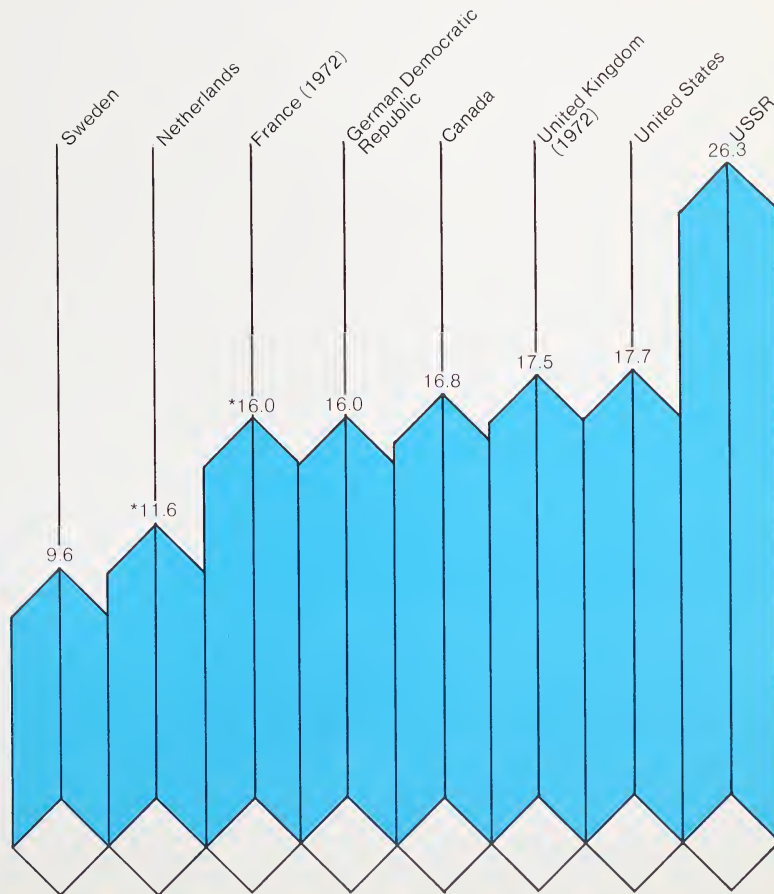
Source: National Center for
Health Statistics

**Infant mortality rates,
selected countries,
1973**

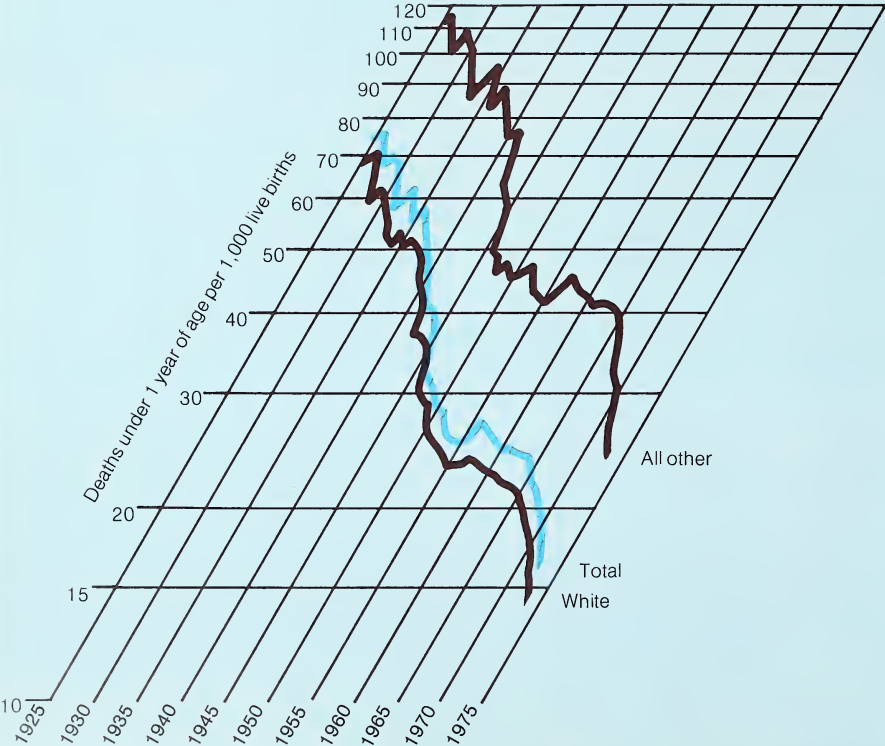
Several countries have lower infant mortality rates than has the United States. A relatively rapid rate of decline in infant mortality rates has been taking place in most countries including the United States.

(Rates are deaths under one year of age per 1,000 live births)

*provisional



Infant mortality rates by
color,
1925-74

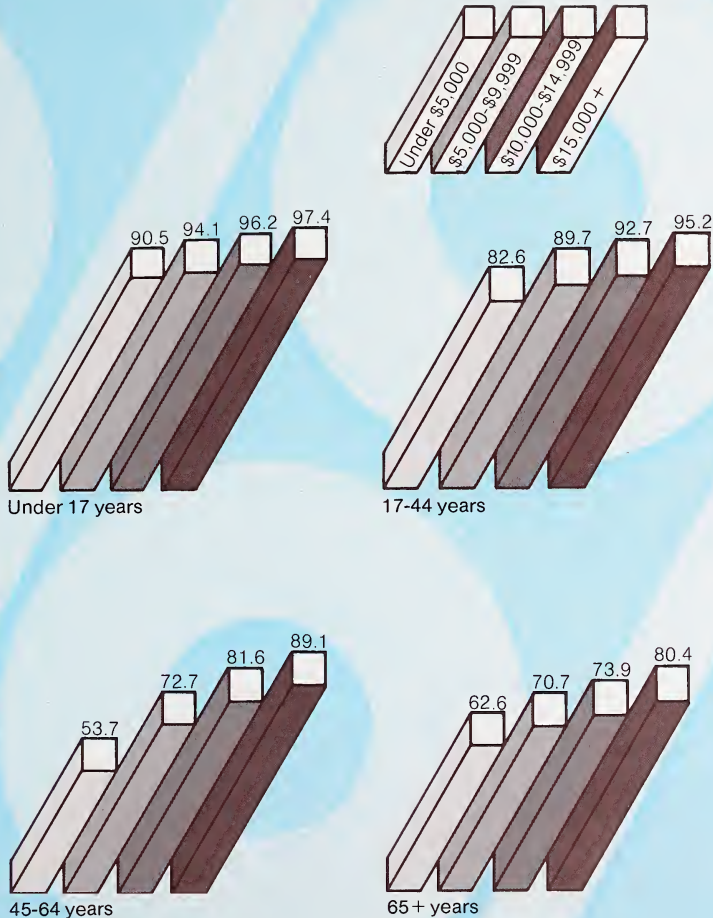


The mortality rate for minority infants was two-thirds higher than the rate for white infants during 1974: the provisional estimates were 24.6 infant deaths per 1,000 live births for minority infants and 14.7 for white infants. Mortality among minority infants has, for the past decade, been declining somewhat more rapidly than for white infants. The resulting narrowing of the gap between minority and white infant mortality rates follows a period of more than 15 years in which the gap had been widening. The recent decrease has brought the ratio of minority to white infant mortality back down to approximately the same level it was in 1950.

Source: National Center for Health Statistics

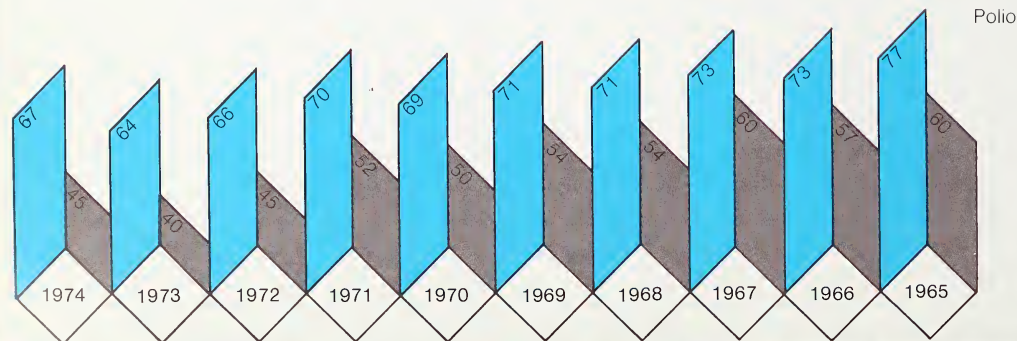
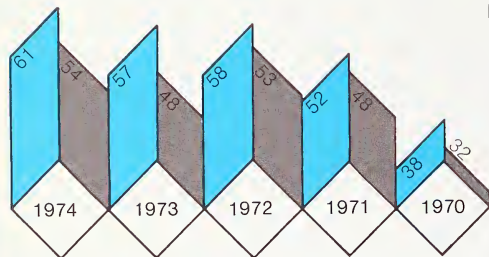
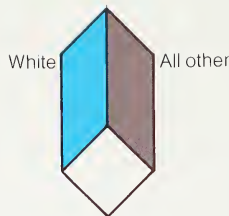
The American people think of themselves as being in good health. In the Health Interview Survey—a national sample survey of the civilian, noninstitutionalized population of the United States—people were asked to compare their health with that of other people their own age. Eighty-seven percent regard their health as excellent or good, nine percent as fair, and only three percent as poor. There are marked differences by family income in the self-assessment of health; for example, among persons 45–64 years of age only 54 percent of the low income persons report their health as excellent or good compared with 89 percent of the high income persons in that age group.

Percent of population who assess their health status as excellent or good in health interviews by family income, 1973



Source: National Center for Health Statistics

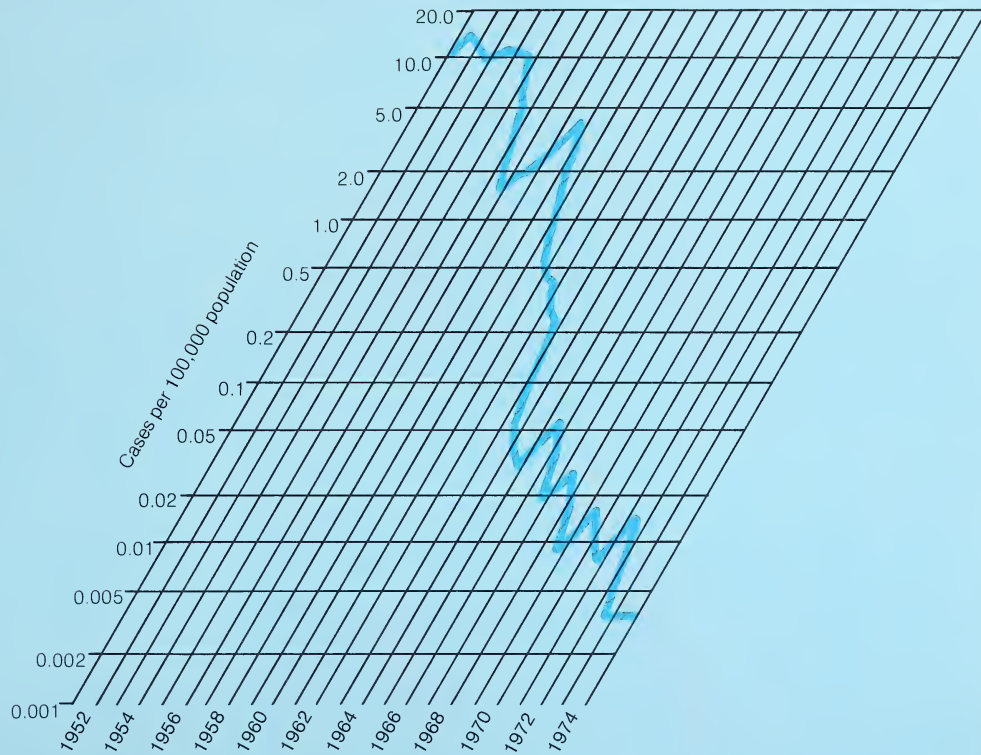
Percent of children ages 1-4
who have been immunized
against polio and rubella, by
color,
1965-1974



The proportion of young children immunized against polio decreased over the past decade. In 1974 two-thirds of all white children 1-4 years of age and less than one-half of other than white children were immunized against polio. Since the introduction of a rubella vaccine in 1969, somewhat over one-half of the children under 5 years of age are protected against this disease.

Source: Center for Disease Control

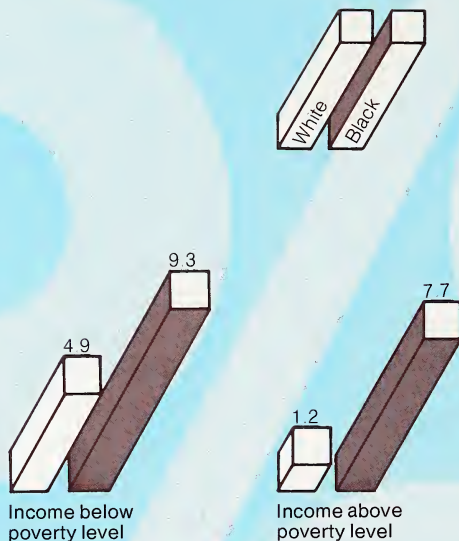
**Poliomyelitis (paralytic)—
reported cases per 100,000
population by year,
1951-1974**



The number of reported cases of paralytic polio in the U.S. has dropped during the past 25 years to a low of only seven cases in 1974. This decline shows one of the more dramatic results of a disease control program which was introduced in the mid-1950's.

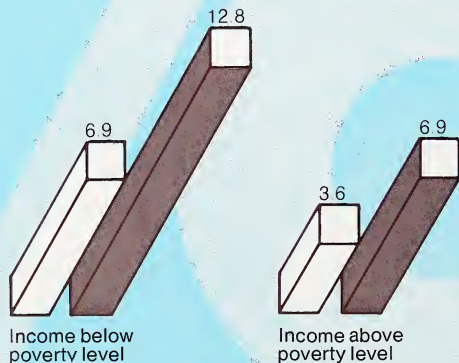
Source: Center for Disease Control

Percent of children ages 1-5
years with low hemoglobin
values, by color for income
levels,
1971-72 (Preliminary)



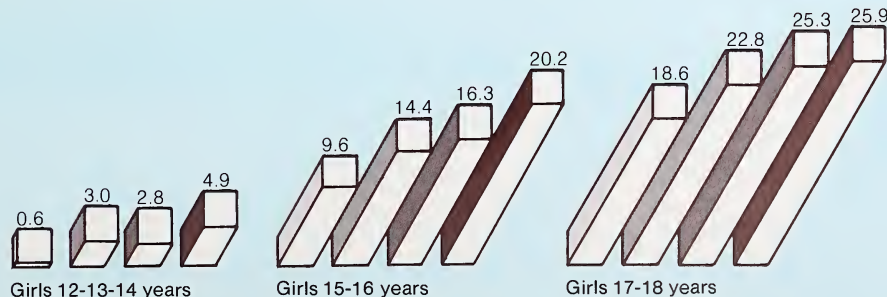
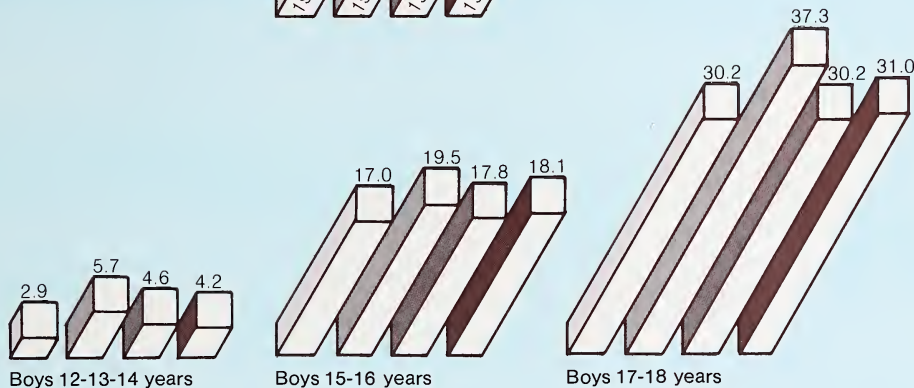
The percent of children with low hemoglobin values is higher among those of families with incomes below the poverty level than above it and among those of black families than of white families. The percent of children with very low iron intakes on a given day follows the same pattern.

Percent of children ages 1-5
consuming less than 3.0
mgs. of iron on a given day, by
color for income levels,
1971-72 (Preliminary)



Source: Health and Nutrition
Examination Survey, National
Center for Health Statistics

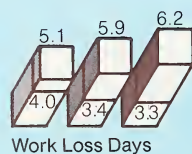
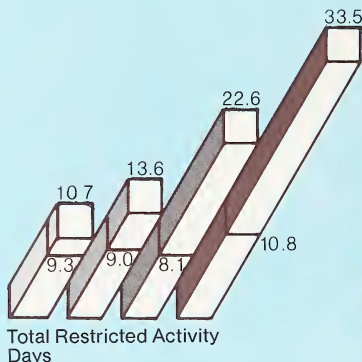
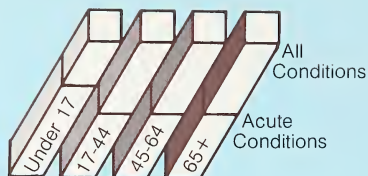
Percent of current regular cigarette smokers among teenagers, by sex and age, 1968-74



Approximately 31 percent of the boys ages 17-18 were regular cigarette smokers in 1974, a smaller proportion than in 1970. The proportion of girls ages 17-18 who are regular smokers, while still lower than that for boys, has increased each year. For younger girls, those ages 15-16, the proportion smoking is higher than that for boys.

Source: Center for Disease Control

Restricted activity days due to all illness and due to acute illness only, 1973



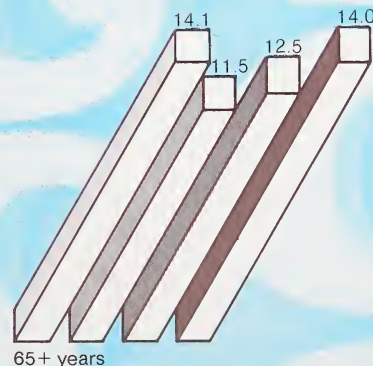
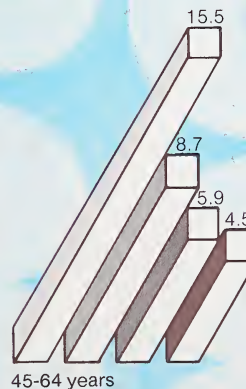
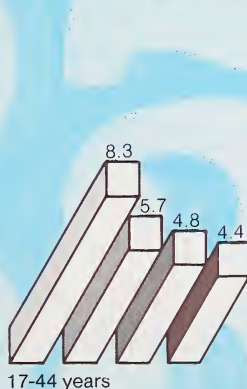
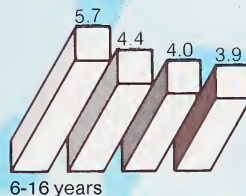
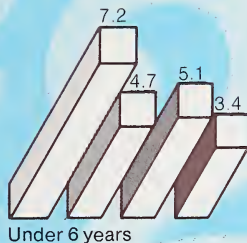
As people get older, illness and injuries cause them to cut down on their usual activities more frequently. Restricted activity days include bed days and work-loss days. Acute illness and injuries are the major cause of restricted activity among children, accounting for 9 out of 10 disability days, but as people get older more of their disability is caused by chronic illness. For the aged, two-thirds of disability days are the result of chronic disease.

Source: Health Interview Survey: National Center for Health Statistics

Number of bed disability days
due to injury or illness, by
family income and age,
1973

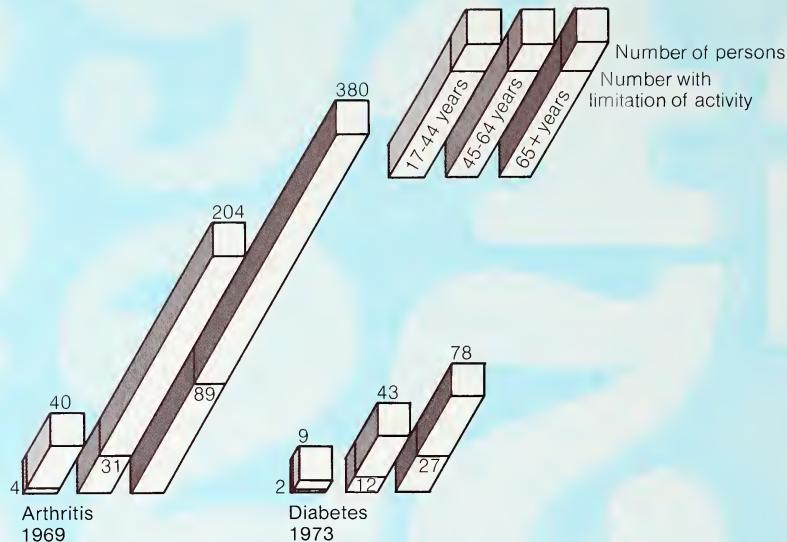


Low income persons spend more days in bed as a result of illness or injury than do high income persons, with the exception of elderly persons. For example, young children in low income families spend twice as many days in bed because of illness and injury than do young children from high income families. At ages 45-64 the differences are almost fourfold; this differential is due in part to the decline in income which frequently accompanies disabling illness.

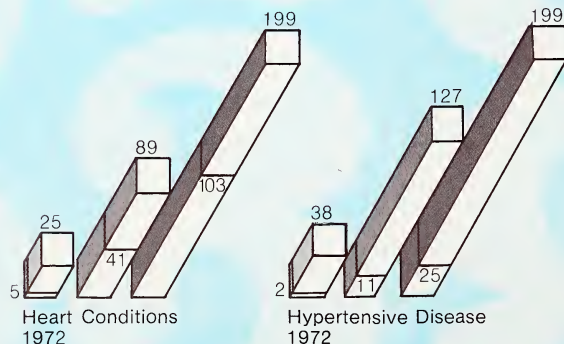


Source: Health Interview
Survey, National Center for
Health Statistics

Number of persons per 1,000 population with selected chronic illness and with limitation of activity due to the illness, by age 1973



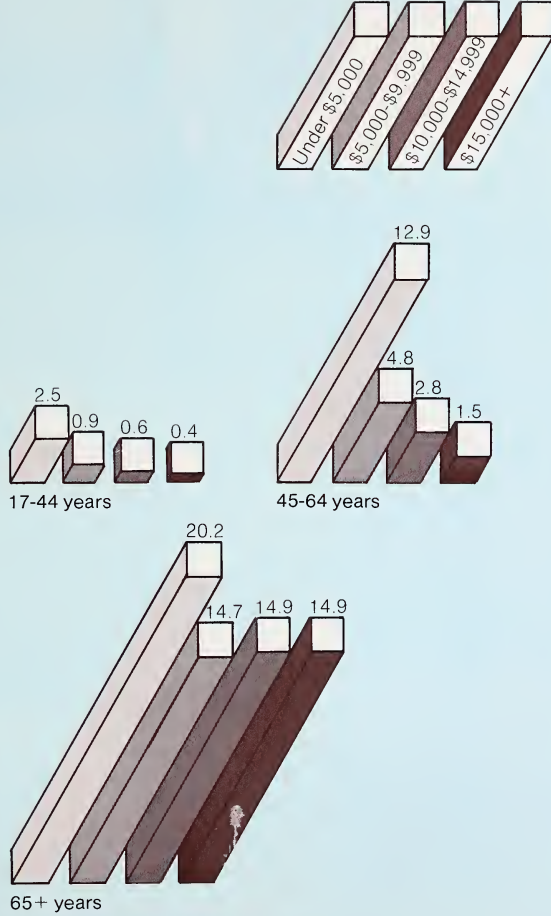
The prevalence of chronic illness rises rapidly with age. For example, one-fifth of the population in the 45-64 age group has arthritis and nearly one in ten has a heart condition. The rates for these diseases are approximately double for the population aged 65 and older. Approximately half of the individuals with a heart condition are limited in their activities by the condition.



Source: Health Interview Survey, National Center for Health Statistics

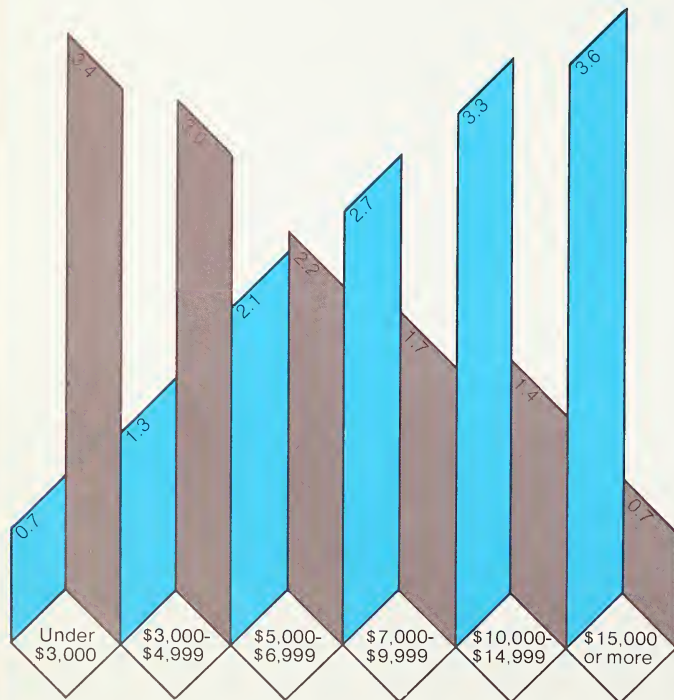
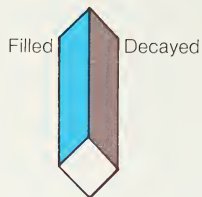
About 3 percent of the civilian, noninstitutionalized population are limited in mobility in some degree as a result of chronic illness. However, about 18 percent of the elderly are limited in their mobility. A greater proportion of the low income population have some degree of mobility limitation than do higher income persons. Almost 13 percent of the low income adults ages 45–64 are limited in their ability to get around as a result of chronic disease, while only 1.5 percent of the middle-aged adults in high income families have such difficulties. The same pattern is found among young adults and to a lesser degree among the aged. Of the 6.5 million persons who are limited in their mobility, about 2.6 million have trouble getting around alone, 2.1 million need help in getting around from either another person or an aid such as a wheelchair and 1.8 million are confined to the house.

Percent of persons with limitation of mobility due to chronic illness, by family income and age, 1972



Source: Health Interview Survey, National Center for Health Statistics

Average number of filled and
of decayed primary and
permanent teeth per child
ages 6-11 years, by family
income, 1963-65.



The children of families with lower incomes have many more untreated decayed teeth and many fewer filled teeth than the children of families with higher incomes.

Source: Health Examination Survey: National Center for Health Statistics

Health in the United States,
1975 :

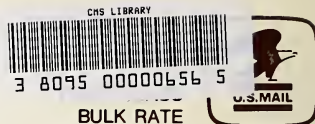
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